Submit Fee-for-Service Claims to Medical Assistance

Receive Timely and Accurate Payments for Covered Services

This chapter shows how to:

- Submit claims using any of the following methods:
  - Direct data entry into ProviderOne.
  - Process online batch submissions (837).
  - Paper.
- Submit Electronic and paper Back Up Documentation On Individual Claims.
- Resolve Errors During a Claim Submission.
- Submit Commercial Insurance secondary claim.
- Saving a claim.
- Submit Medicare Crossover Claims.
- Check On The Progress Of a claim.
- Submit claim Adjustments.
- Resubmit a Denied Claim.
- Void a Paid Claim.
- Creating a template claim.
- Submitting a template claim or a batch of template claims.

Why Is Correctly Billing Medical Assistance Important?

This chapter is designed to help providers submit claims correctly to reduce the need to resubmit claims. All the instruction up to this point will increase success in billing Medical Assistance and getting reimbursed in a timely manner.

When providers determine that the client is eligible for Medical Assistance, the service is covered, Medical Assistance is the primary payer, and any authorization requirements have been fulfilled (if required), providers may bill Medical Assistance after the service is rendered.

Disclaimer

A contract, known as the Core Provider Agreement, governs the relationship between the Agency and Medical Assistance providers. The Core Provider Agreement's terms and conditions incorporate federal laws, rules and regulations, state law, the Agency rules and regulations, and the Agency program policies, numbered memoranda, and billing instructions, including this Guide. Providers

must submit a claim in accordance with the Agency rules, policies, numbered memoranda, and billing instructions in effect at the time they provided the service.

The Agency does not assume responsibility for informing providers of national coding rules. Claims billed in conflict with national coding rules will be denied by the Agency. Please consult the appropriate coding resources.

The Key Steps

1. Determine Claim Submission Method
2. Determine if Claim Needs Backup
3. Submit New Claims and Backup via:
   a. Direct Data Entry into ProviderOne
   b. Direct Data Entry a Commercial Insurance Secondary Professional Claim
   c. Saving a Direct Data Entry Claim
   d. Online Batch Claims Submission
   e. Paper
4. Submit Medicare Cross-Over Claims
5. Inquire about the Status of a Claim
6. Adjust, Resubmit, or Void a Claim
7. Creating a Template Claim
8. Submitting a Template Claim or a Batch of Template Claims

Key Step
1

1. Determine Claim Submission Method

Why?

The Agency wants providers to receive timely payments. Providers usually base their claim submission method decision in part on the volume of claims billed and the level of technology they have available.

We encourage providers to submit claims electronically. Electronic claims typically process much faster than paper claims. Information on the claim will remain the same regardless of the billing method used.

How

Select one of the methods below:

- **Direct Data Entry of individual claims into ProviderOne** – ProviderOne enables providers to submit new claims, check claim status, submit adjustment claims, revive denied claims, and attach electronic backup documentation to claims. Updates to ProviderOne claim options enable providers to create and save template claims, create a claim from the template and also create batches of claims using saved templates.
- **Electronic Batch Claim – Self Submission**. Electronic claims are submitted to the Agency directly by the provider. Providers use a companion guide[1] to keep their software up to date. Electronic Batch submitters are required to pass testing with the Agency and have a Trading Partner Agreement (TPA)[2].
- **Electronic Batch Claim Submission – Billing Agent or Clearinghouse**. Electronic claims are submitted to the Agency through a Billing Agent or Clearinghouse**.** These companies use a companion guide to keep their software up to date. Electronic Batch submitters are required to pass testing with the Agency and have a Trading Partner Agreement (TPA).
- **Paper Claim Submission**
  - Institutional (i.e. hospitals, nursing homes, hospice, home health, kidney centers) claims are submitted on a UB-04 claim form.
  - Professional (e.g. physician) claims are submitted on a CMS-1500 claim form (version 08/05)
  - Dental claims are submitted on a 2006 ADA form.
  - Medicare Crossover (e.g. Professional or Institutional) claims are submitted on a UB-04 or CMS-1500 claim form (the same form used to bill Medicare).

Pitfalls

Submitting paper claims. Electronic claims process much faster than paper claims.

[1] ProviderOne companion guides are located at http://hrsa.dshs.wa.gov/dshshipaa/
[2] Trading Partner Agreements are located at http://hrsa.dshs.wa.gov/providerenroll/

Key Step
2

2. Determine if Claim Needs Backup

Why

Claims billed to the Agency may need backup documents if the client has:

- Commercial Private Insurance
- Medicare
- Medicare Advantage Plan

You must attach backup documentation to a paper or electronic claim when a specific type of service requires additional information. Examples of these back up documents include:

- Invoices for Acquisition Costs (AC)
- By Report (BR) services
- Operative Reports or other documents, if required or requested by the Agency

How

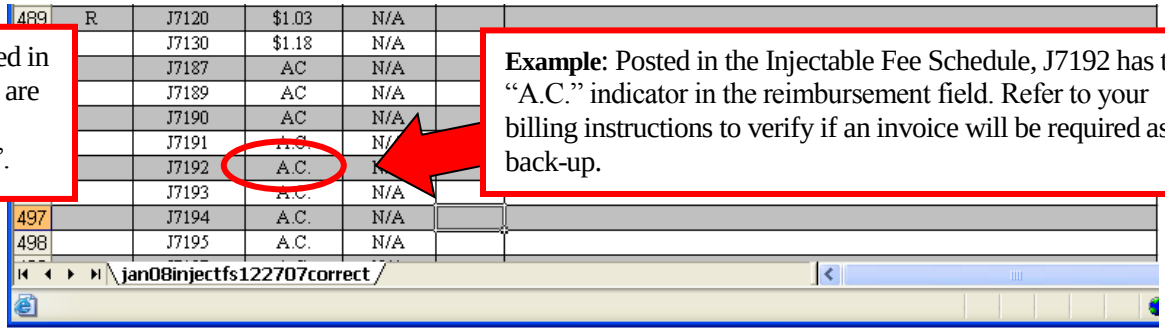
Explanations of Benefits (EOB) may be needed if there is a primary payer.

- If a provider is submitting an EOB with a claim, the information on the claim must match the line information billed to the primary payer as reflected on the EOB.

Documentation is needed for some services.

- Acquisition Cost (AC) and By Report (BR) services are listed in the fee schedules. Review Fee Schedules at http://hrsa.dshs.wa.gov/RBRVS/Index.html.

Some codes listed in the fee schedule are denoted with an "A.C."or "B.R.".



Example: Posted in the Injectable Fee Schedule, J7192 has the "A.C." indicator in the reimbursement field. Refer to your billing instructions to verify if an invoice will be required as back-up.

- **Drugs** with an **AC** indicator in the fee schedule with billed charges of $1,100.00 or greater, or **Supplies** with billed charges of $50.00 or greater, require a manufacturer's invoice in order to be paid. Attach a copy of the invoice to the claim and note the quantity given to the client in the *Comments* section of the claim form. It is not necessary to attach an invoice to the claim for procedure codes with an AC indicator in the fee schedule for drugs with billed charges under $1,100.00, or supplies with billed

charges under $50.00, unless requested by the Agency. Bill only **one** unit of service on the claim. See Section C of the Physician-Related Services Billing Instructions for additional information.

- Services with a **BR** indicator in the fee schedule with billed charges of $1,100.00 or greater require a detailed report in order to be paid. The report describes the nature, extent, time, effort, and/or equipment necessary to deliver the service and must be attached to the claim. It is not necessary to attach a report to the claim for services with a BR indicator in the fee schedule with billed charges under $1,100.00 unless requested by the Agency. See Section C of the Physician-Related Services Billing Instructions for additional information.

- The Agency may deny a claim and request an Operative Report to justify medical necessity for services.

Pitfalls

- **Failing to include required back up information with the claim. This will result in claim denial.**
- **Billing services that were not billed to the primary payer. This will cause the claim to be denied.**
- **Failing to check eligibility to determine if another payer exists.**

Key Step
3

3. Submit New Claims and Backup:

a. Direct Data Entry into ProviderOne
b. DDE - Commercial Insurance Secondary Professional Claim in ProviderOne
c. Saving a Direct Data Entry Claim
d. Online Batch Claims Submission
e. Paper

Why

- The Agency offers multiple free methods to submit claims for payment for services supplied to our clients. The Agency encourages providers to bill by some type of electronic method to optimize payment receipts and to improve resubmission turnaround time in case a claim is denied for a billing error. This section will cover the billing methods available in detail.

- It is important to submit claims within the timelines allowed to ensure payment.

Initial Claims [WAC 182-502-0150 (3)(4)]
Providers must submit their claims to Medical Assistance and have a transaction control number (TCN) assigned by ProviderOne within 365 days from any of the following:

- The date the service was furnish to the eligible client;
- The date a final fair hearing decision is entered that impacts the particular claim;
- The date a court orders the Agency to cover the services; or
- The date the Agency certifies a client eligible under delayed certification criteria.

The Agency may grant exceptions to the 365-day time limit for initial claims when billing delays are caused by either of the following:

- The Agency certification of a client for a retroactive period; or
- Providers prove to the Agency that there are extenuating circumstances.

Note: The Agency follows the National Correct Coding Initiative (NCCI) policy. The Centers for Medicare and Medicaid Services (CMS) created this policy to promote national correct coding methods. NCCI assists the Agency to control improper coding that may lead to inappropriate payment. The Agency bases coding policies on:

- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) manual
- National and local policies and edits
- Coding guidelines developed by national professional societies
- The analysis and review of standard medical and surgical practices
- Review of current coding practices

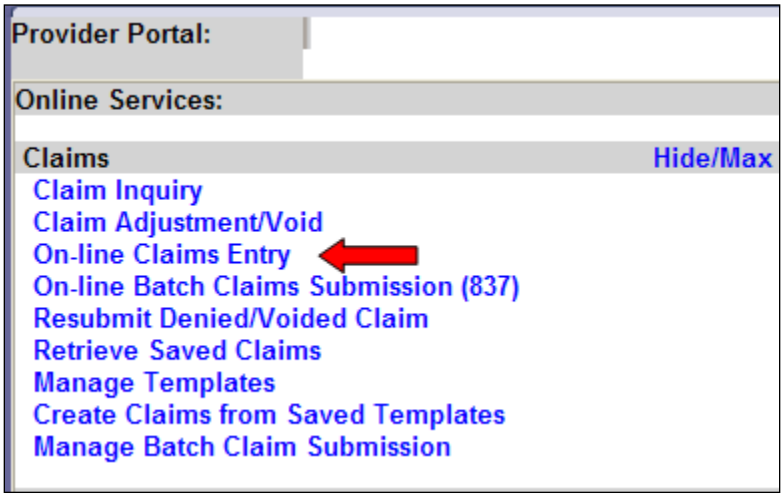
How

3a. Direct Data Entry (DDE) Into ProviderOne

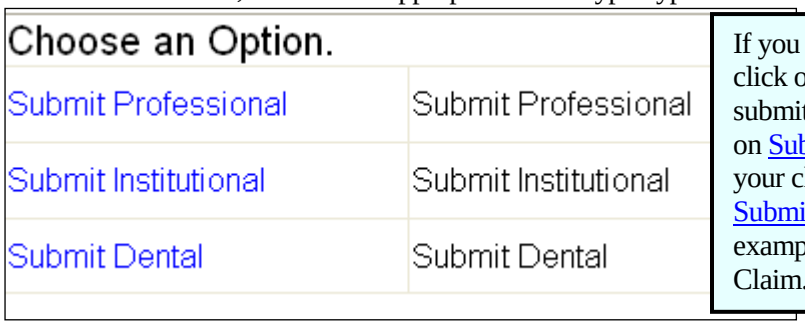
- Log into ProviderOne and choose the **EXT Provider Claims Submitter** or **EXT Provider Super User** profile.

It is extremely important before proceding any farther into the claim submission process to **TURN OFF** the **POP UP BLOCKER** on the web browser. ProviderOne utilizes pop up windows durning the claim submission process and submitters will not see those if the pop up blocker is turned on.

- From the ProviderOne home page (Provider Portal), click on the "On Line Claims Entry" hyperlink.



To create a new claim, click on the appropriate claim type hyperlink.

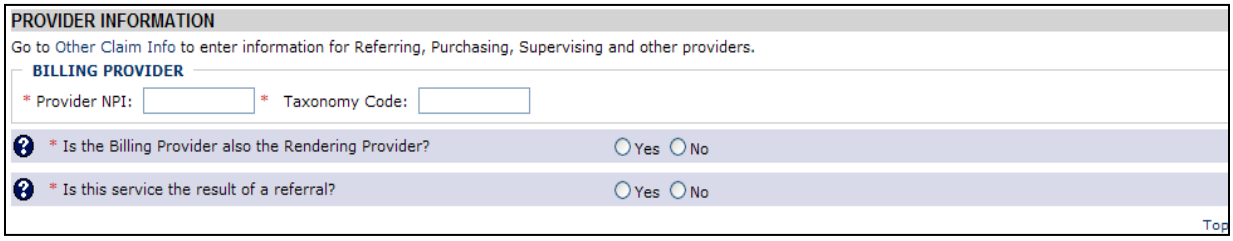


If you submit your claims on a UB-04 form click on Submit Institutional Claim. If you submit your claims on an ADA form, click on Submit Dental Claim. If you submit your claims on a CMS-1500 form, click on Submit Professional Claim. For this example we will use Submit Professional Claim.

Complete the data fields required and any additional information needed. If a provider has questions regarding billing policies, please refer to the appropriate billing instructions for the claim type. For convenience, there is a link to the billing instructions at the top of the DDE claim page.

Submitting a Professional Claim

Enter the billing provider's NPI number and taxonomy code. (See Memo 10-22) Depending on how the next two questions are answered, additional NPI numbers and taxonomy codes may have to be entered for those providers. For more information on taxonomy codes, please see Appendix L.

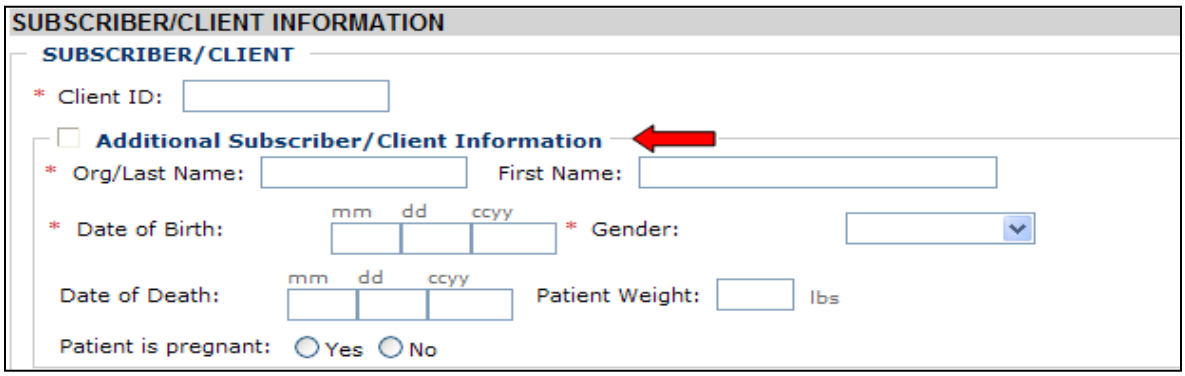


How do I answer the questions?

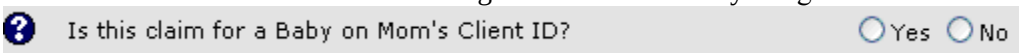
- For a solo practice office, the Billing Provider would also be the Rendering Provider.
- For a clinic or group practice, the Billing Provider would not be the Rendering Provider. Answer this question "**No**" and then fill in the NPI/Taxonomy for the provider that rendered the service at the clinic.
- If the service provided is the result of a referral from another Medicaid enrolled provider, answer "**Yes**" and enter that provider's NPI. A taxonomy code is not required for a referring provider.

Client information

Enter the ProviderOne client ID (e.g. 123456789WA) and expand the box by clicking the red plus sign to enter the client's name, birthday, and gender. **Client's birthdate, last name, and gender are required on all claims.** While the first name is optional, if entered, the first name will also be printed on the provider's RA. When billing for a newborn claim using mom's ID, enter the baby's name, baby's birthdate, and the baby's gender in the boxes instead of mom's information.



Click "Yes" on the radio button if indicating the claim is for a baby using mom's ID.



The next data element is a question about Medicare and we will discuss that in detail in **Key Step 4** below.

If the claim requires authorization, click on the Prior Authorization expander and enter the authorization number.

Sometimes a claim note needs to be added to the claim so that it processes correctly. To add a note, click on the red plus sign to expand the note option, then type in the note information keeping it short.

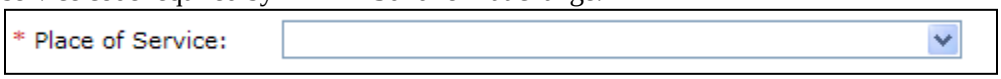
Some of the reasons to add a note or claim indicator are:

- "SCI=B" for baby on moms ID
- "SCI=I" for Involuntary Treatment Act (ITA)
- "SCI=V" for voluntary (psych) treatment
- "SCI=F" for Enteral Nutrition – Client not eligible for WIC
- Twin A, or Twin B; or Triplet A, Triplet B, or Triplet C if newborns on mom's ID
- "Sending Insurance EOB" if mailing the primary insurance back-up

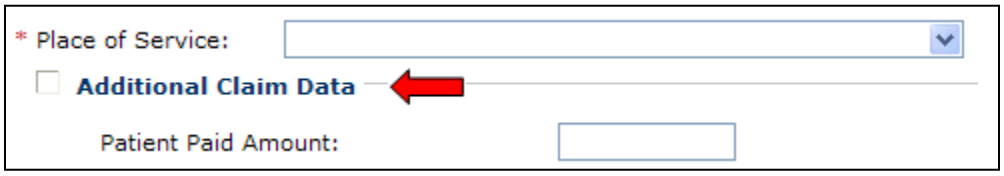
Answer the next question.

Use the "Patient Account No" field to enter any internal patient account numbers used. This information will be printed on the Remittance Advice.

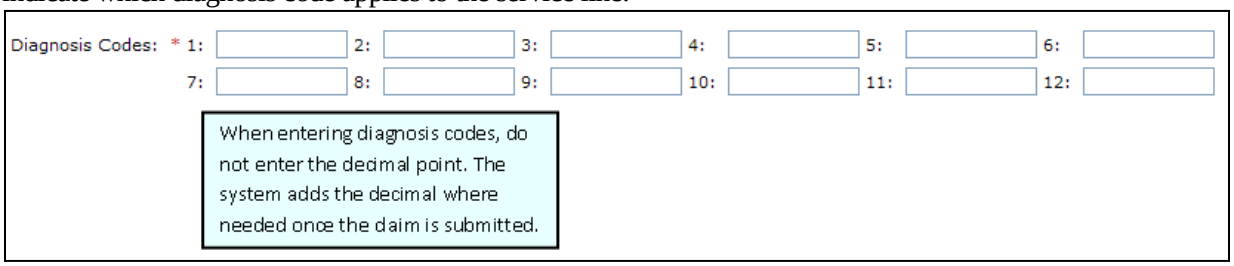
Enter the Place of Service code number using the drop down option. This is a new location for the place of service code required by HIPAA 5010 format change.



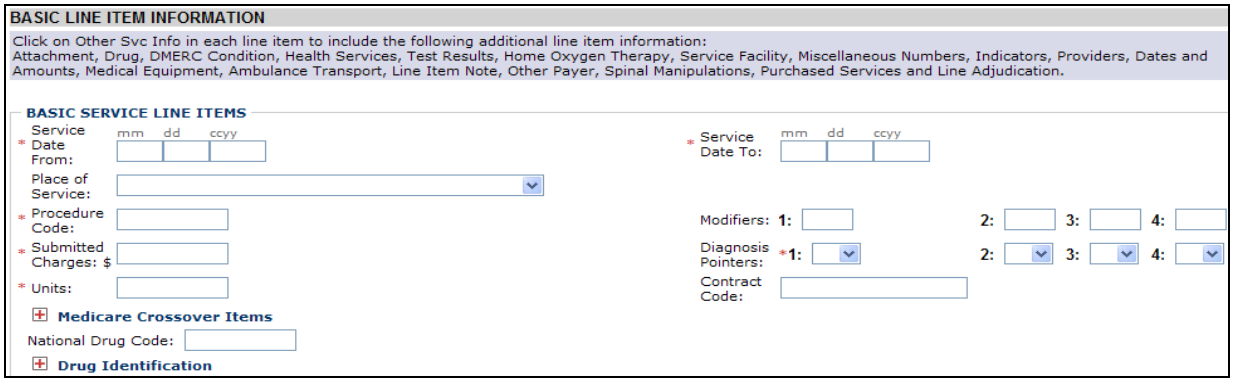
If a client has a spend down and that spend down amount needs to be reported on the claim, expand the **Additional Claim Data** field and enter the spend down amount in the "Patient Paid Amount" box.



Now enter the diagnosis codes. HIPAA allows up to 12 fields for diagnosis codes. Later a pointer is used to indicate which diagnosis code applies to the service line.



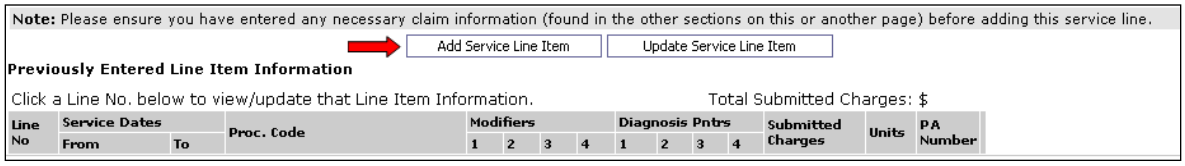
Next enter the basic line item information. Using the "tab" key can speed up filling out the claim form.



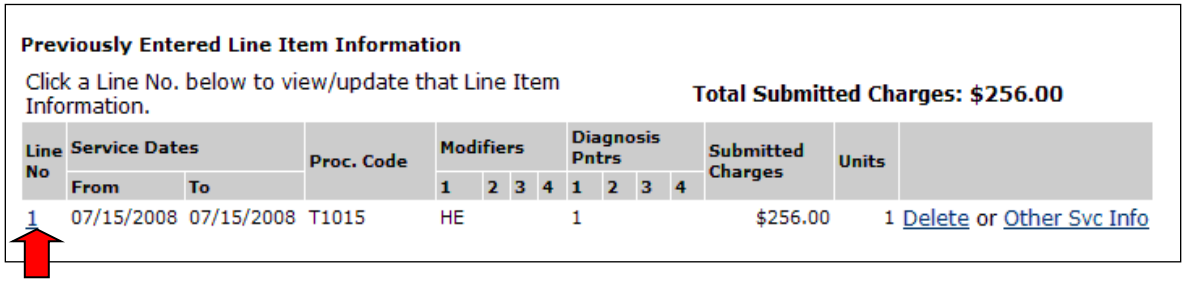
- Enter the "from" and "to" date of service. Enter date spans here for equipment rental, etc. then tab;
- Use the drop down option to indicate the place of service (optional, as the date of service has already been entered at claim level);
- Enter the procedure code being billed on this line, then tab;
- Enter the Modifier (s) if appropriate, then tab thru the other boxes;
- Enter the billed amount. (whole dollar amounts do not need a decimal point), then tab;
- Indicate using the diagnosis pointer number which diagnosis from above will be used on this line. It is possible to indicate multiple diagnosis for the line, or just tab thru;
- Enter the number of units to be billed. At least one unit must be indicated.

Enter a National Drug Code (NDC) only if you are billing a code that requires the NDC. If not required skip the box.
The expander here for Medicare Crossover Items will be discussed in **Key Step 4** below.

Then click on Add Service Line Item.



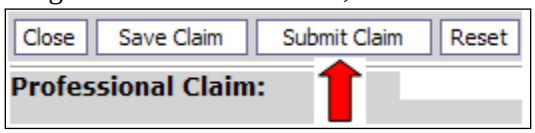
The entered line information will appear under the section named "Previously Entered Line Item Information". Make sure every line has the correct information and appears under this section before submitting the claim.



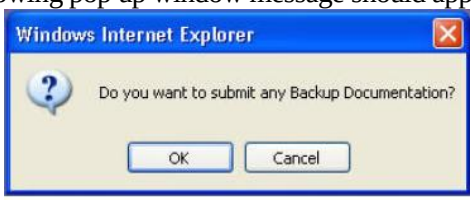
Need to edit that line due to a keying error or coding mistake?
Simply click on the line number of the line to correct; the system then repopulates the service line items boxes. Make the changes as necessary, then push the Update Service Line Item button. The system will change the original coding line to the corrected information.

Quick Tip: Providers can use a "shortcut" when adding more lines to the claim. Use the edit feature of the system to quickly add more lines. Click on the line number to repopulate the service line items boxes. Now add the information for the next line by overwriting what is there, only changing what is different. Generally speaking, only a procedure code and the billed amount would change, or in some cases the codes are the same but the date of service would be changed. Once the information is updated as needed, click on the Add Service Line Item button to add the new line. Repeat this process to add line 3 and 4 etc.

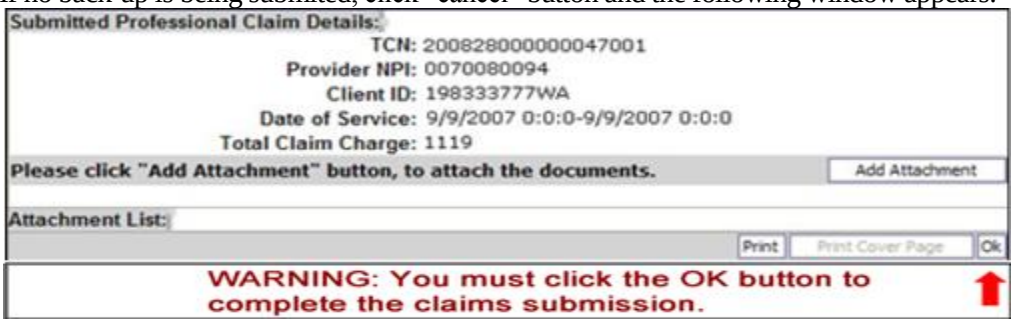
After entering all the claim information, click on "Submit Claim" button at the top of the screen.



The following pop up window message should appear:



If no back-up is being submited, click "cancel" button and the following window appears:



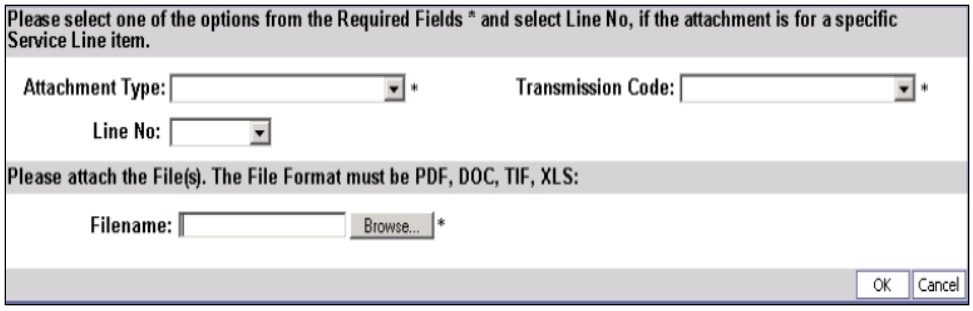
Clicking **OK** submits the claim to ProviderOne and returns to an blank claim screen ready to enter another claim.

Submitting Backup Documentation to a DDE Claim

ProviderOne allows the biller to submit backup two ways to the DDE claim:

- Add a electronic attachement file
- Submit paper backup with a cover sheet

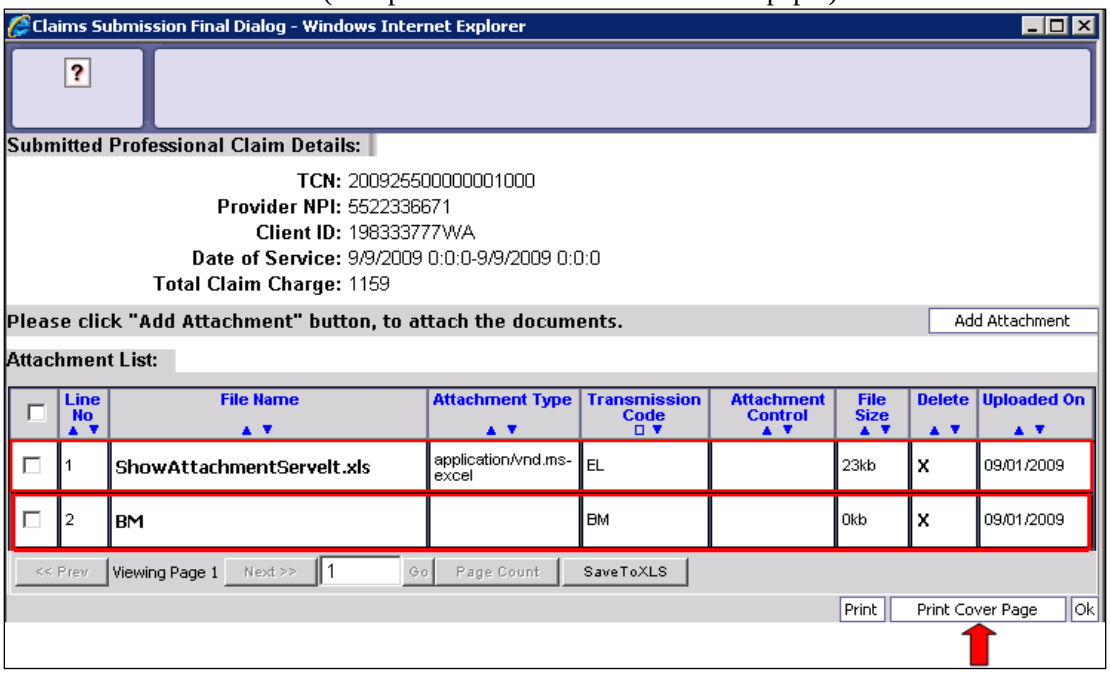
If backup will be submitted with the above claim, clicking "OK" on the Backup Documentation pop up window is followed by this screen:

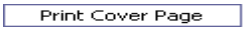


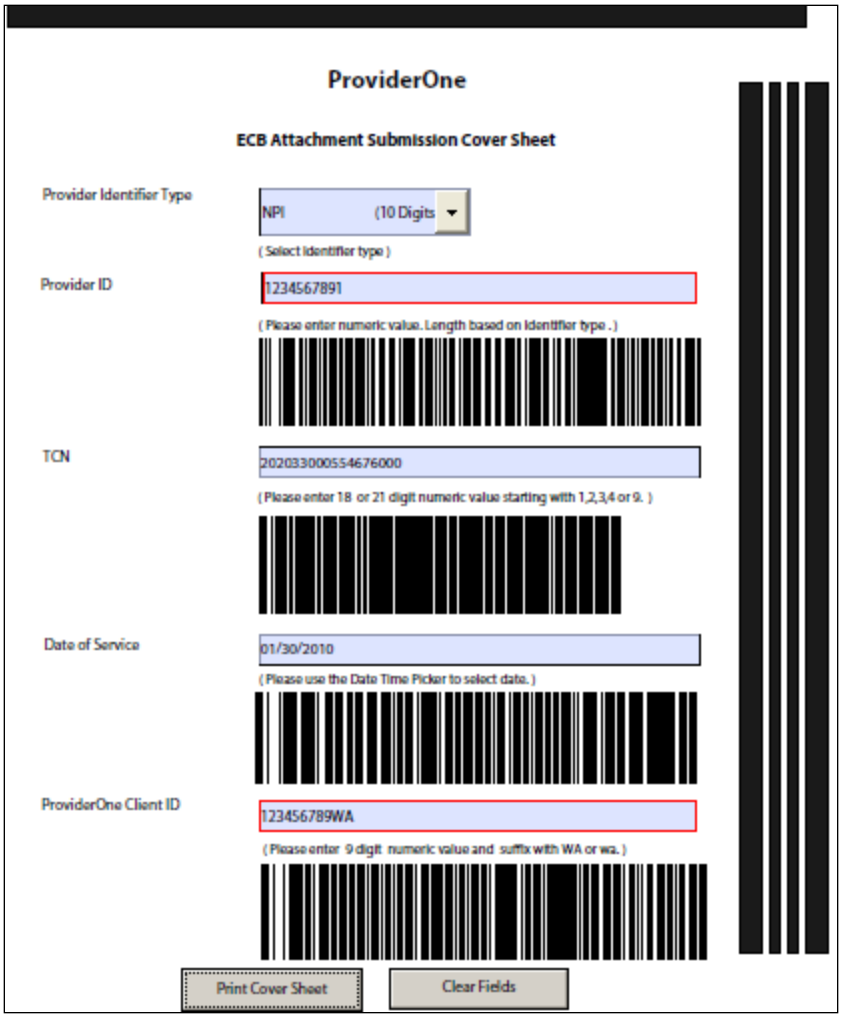
Fill in the fields:

- Pick the Attachement Type from the drop down list
- The Transmission Code would be by mail or electronic
- Line No is not required
- Add an electronic attachment using the Filename field if using this option
- Click on the OK button when completed

A claim sent via Direct Data Entry (DDE) in ProviderOne can have an electronic image of any backup attached to that individual claim. (This picture shows both electronic and paper).

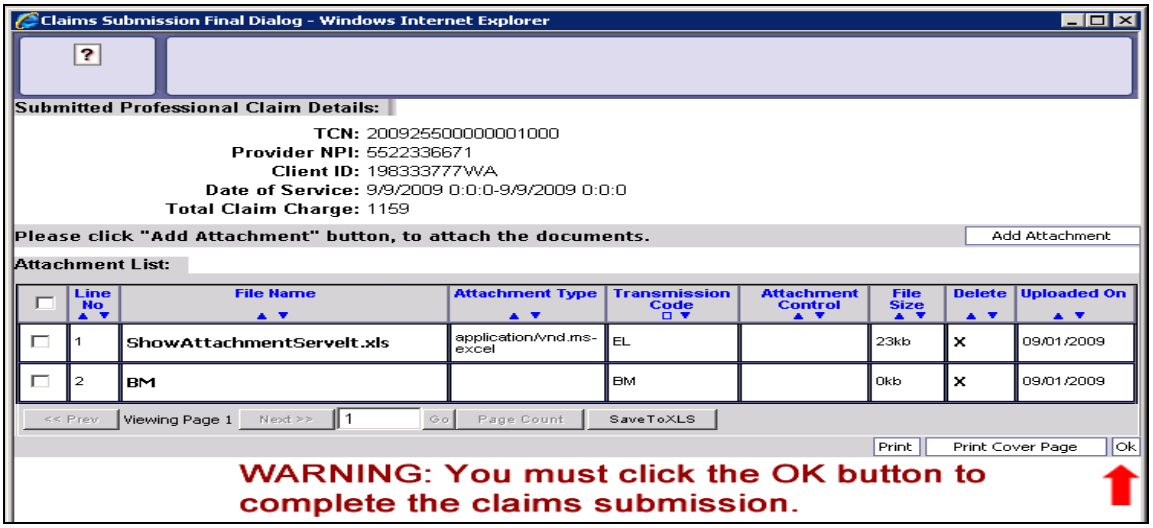


If sending paper back up to the DDE claim, click on the **Print Cover Page**  button. When the cover sheet downloads, fill in the information required, print and send the back up and cover sheet to the Agency at the address or fax number below. Below is an example of a cover sheet. The barcodes expand once the data fields are filled and the cursor is moved to the next field or simply hit the "enter" key.



- If a provider skips the above step and needs to print a cover sheet, the cover sheets can be located at http://hrsa.dshs.wa.gov/download/Index.htm. All supporting documentation requires an Agency cover sheet. For more information on cover sheets, please visit Appendix G.
- When finished attaching backup, click "OK" to submit the claim.

Note: When filling out the cover sheet, be sure to fill in all fields with information. Do not add a zero to any field if the information for that field is not available when filling out the cover sheet. Obtain the information, then fill in the fields and print. Do Not save the cover sheet for reuse as each cover sheet is specific to the document being sent to the Agency. Please do not use any software other than **ADOBE** for opening and generating the coversheet. The barcode used to link documents will not work properly using other software.



Note: Electronic back up image files are limited to 2 mega bytes in size.

- E-BU images can also be attached to adjusted claims.
- E-BU images can also be attached to fixed resubmitted denied claims.

- Paper backup submittal for claims submitted DDE
  - Attach a ProviderOne cover sheet to the back-up documents and send them to:

    Electronic Claim Back-up Documentation (ECB)
    PO Box 45535
    Olympia, WA 98504-5535
  - Fax to 1-866-668-1214

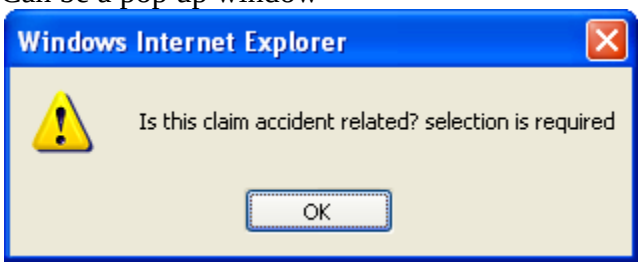
Resolving DDE claim submission errors

During the process of submitting a DDE claim, ProviderOne does a data check prior to submission to verify if all:

- Fields contain valid entries
- Required fields are completed
- Required questions are answered

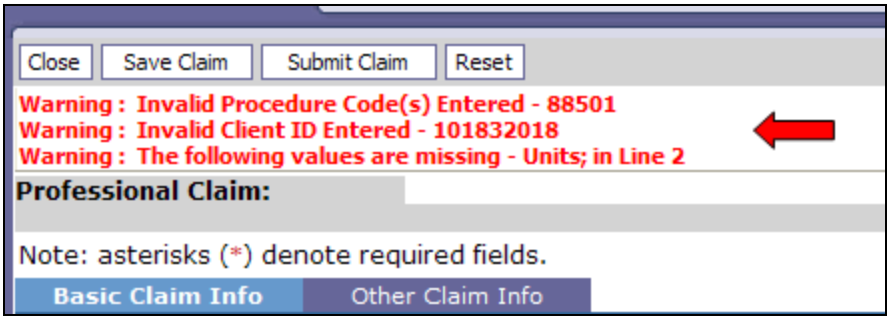
Errors can come in a two formats.

- Can be a pop up window



Go back and answer the required question missed during claim data entry.

- Or can be a red text messages at the top of the claim form screen

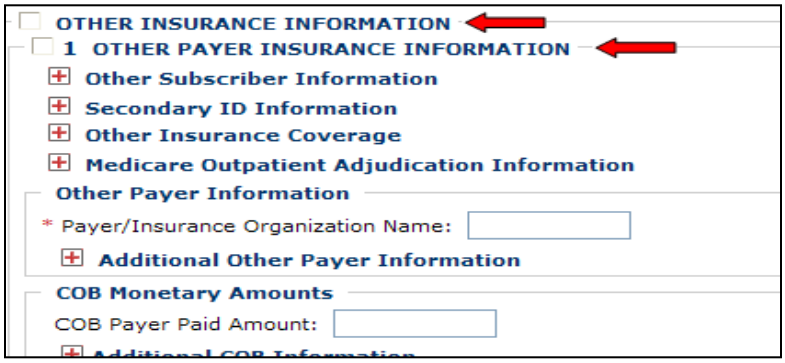


These three errors are probably caused by hurrying during the data entry process. Fix the keying error on the code, add the "WA" to the client ID number, and add the missing unit to the service line.

Once all errors are fixed, try submitting the claim again.

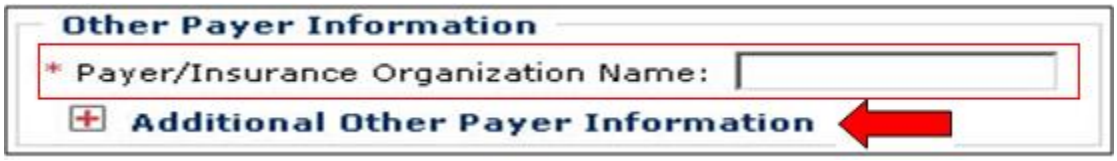
3b. Direct Data Entry - Commercial Insurance Secondary Professional Claim into ProviderOne

Under the Medicare question, expand the "**Other Insurance Information**" section.
Then expand the "**1 Other Payer Insurance Information**" expander for the first insurance. The system now has the ability for the provider to enter more than one insurance company's information.

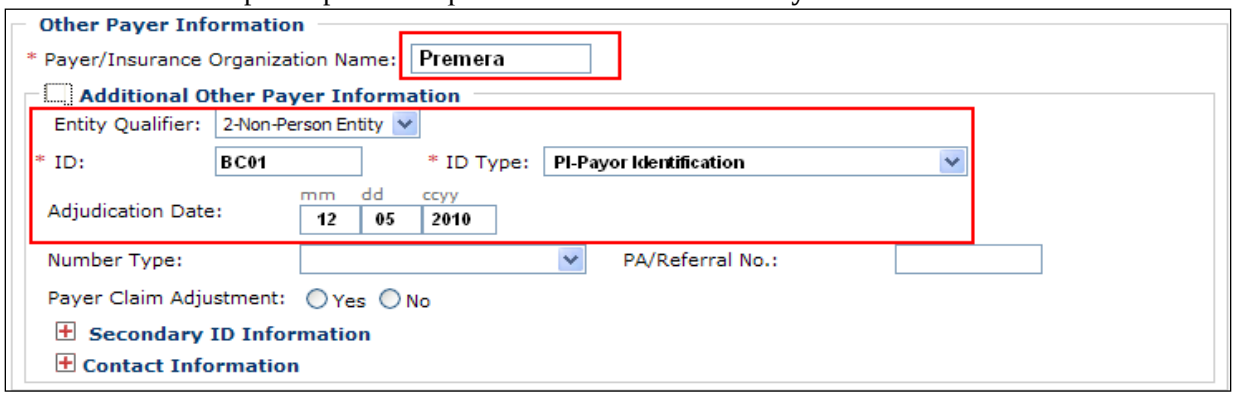


Do **not** enter Medicare or Managed Medicare (Medicare Part C) information here. HCA does not consider them commercial insurance.

When the "**1 Other Insurance Information**" screen opens, skip directly to the "**Other Payer Information**" section and enter the name of the Insurance Company.



Then click on the red plus expander to open the "**Additional Other Payer Information**" section

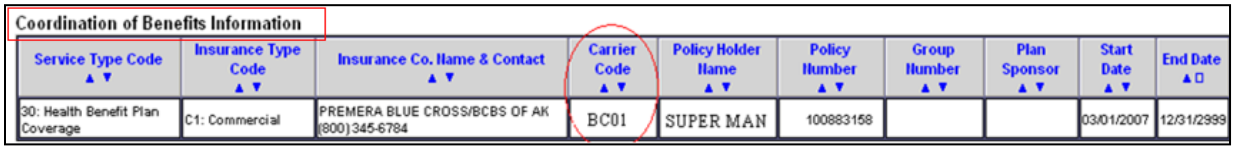


Enter the:

- Entity Qualifier
- Payer ID number
- Payer ID Type
- Adjudication (payment) Date

What is the ID number of the Insurance Company?

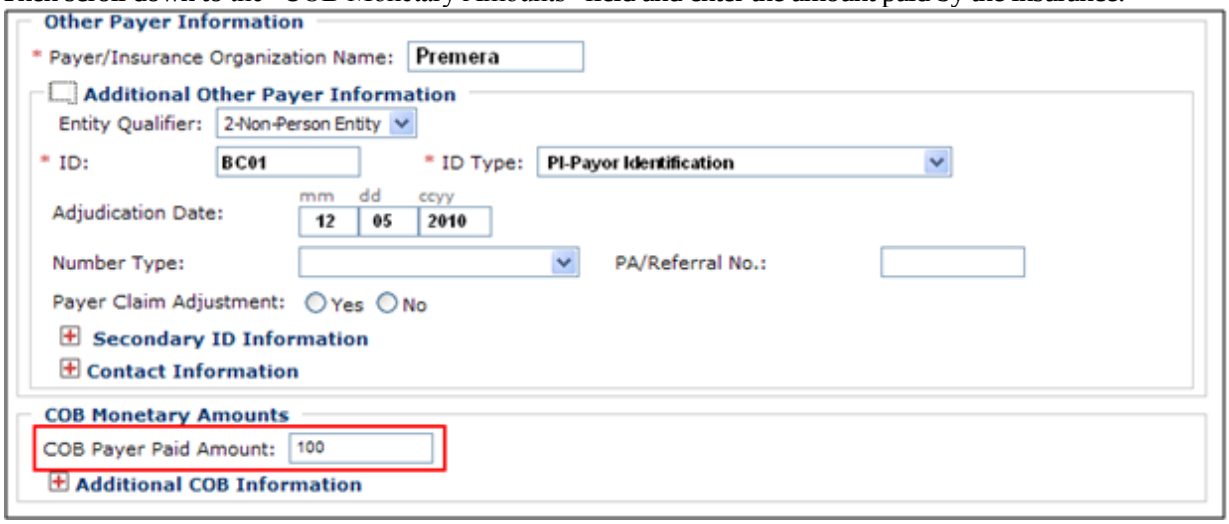
The Agency would prefer that the Insurance carrier code be used on these claims as the ID number; the carrier code can be found on the client's eligibility file in ProviderOne. Conduct an eligibility check for the client; under the Coordination of Benefits section, it would show **BC01** for this client.



Coordination of Benefits Information

Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	PREMERA BLUE CROSS/BCBS OF AK (800) 345-6784	BC01	SUPER MAN	100883158			03/01/2007	12/31/2999

Then scroll down to the "COB Monetary Amounts" field and enter the amount paid by the insurance.



Other Payer Information

* Payer/Insurance Organization Name: Premera

Additional Other Payer Information

Entity Qualifier: 2-Non-Person Entity

* ID: BC01 * ID Type: PI-Payor Identification

Adjudication Date: mm 12 dd 05 ccyy 2010

Number Type: PA/Referral No.:

Payer Claim Adjustment: Yes No

Secondary ID Information

Contact Information

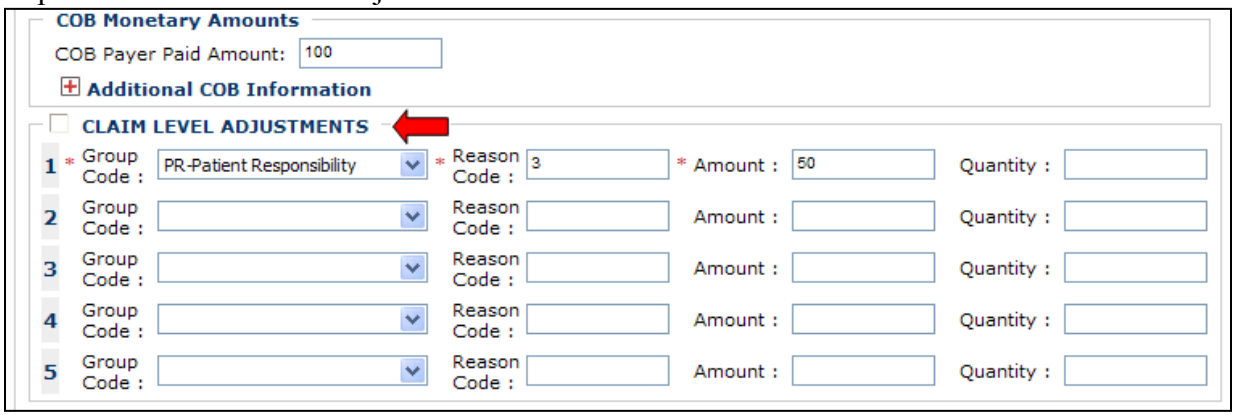
COB Monetary Amounts

COB Payer Paid Amount: 100

Additional COB Information

Providers can avoid sending in the insurance EOB with this claim by following the next steps.

Expand the "Claim Level Adjustments" section.



COB Monetary Amounts

COB Payer Paid Amount: 100

Additional COB Information

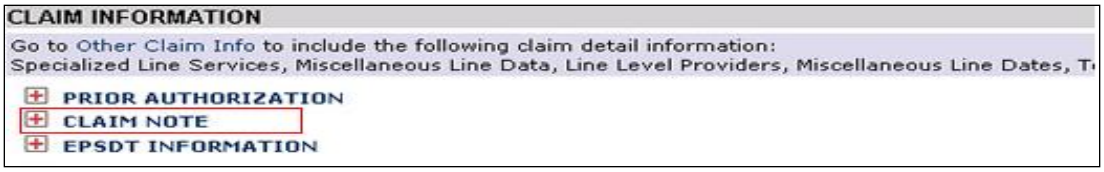
CLAIM LEVEL ADJUSTMENTS

		Group Code :	Reason Code :	Amount :	Quantity :
1	*	PR-Patient Responsibility	* 3	* 50	
2					
3					
4					
5					

Enter the HIPAA Adjustment Reason Code information from the insurance EOB:

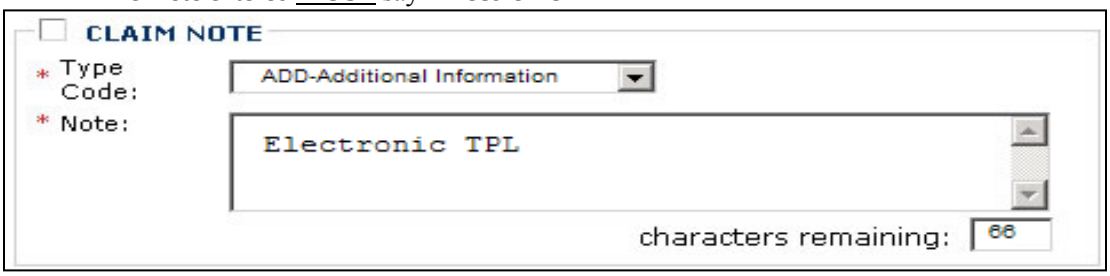
- Group Code (choose from the options)
- Reason Code (only the HIPAA reason code number is required)
- Amount (enter a zero if billing services denied by the insurance company)

Add a claim note by expanding the claim note section.



And then enter:

- Type Code will be "ADD-Additional Information"
- The Note entered MUST say "**Electronic TPL**"



Finish filling in the rest of the claim data and submit the claim as outlined above in section **3a.**

Note: Providers can use this process to submit claims or claim lines denied by the insurance company, as well as claims or claim lines paid by the insurance company. The Agency can process the claims with these data elements:

- Name of the insurance company and the Agency carrier code
- Amount paid by the insuranc company (enter zero if no payment)
- The HIPAA Adjustment Reason Codes for payment/non-payment.

DO NOT submit paid lines and denied lines of service on the same claim form. Split the billing into two claims if necessary.

For more information on billing Medicaid secondary, follow along with the presentation slides found at http://hrsa.dshs.wa.gov/pdf/provider/Webinar/SubmitProfessionalclaimwithPrimaryIns.pdf.

Third-Party Liability

If the client has commercial insurance coverage (excluding Medicare), prior authorization (PA) is not required prior to providing any service requiring PA. However if the commercial insurance denies payment for the service that required PA, providers must then request authorization and include a copy of the insurance denial EOB with the request. See the PA chapter for submitting a request.

How to bill Medicare Crossover Claim via the DDE claim form is covered in Key Step 4 following this section.

3c. Saving a Direct Data Entry Claim

ProviderOne now allows a provider to save a claim if the provider is interrupted during the process of entering a claim, and allows retrieving that saved claim to finish and submit the claim. The following data elements are required to be completed before a claim can be saved:

Provider Information

- Billing Provider NPI
- Billing Provider Taxonomy
- Question: Is the Billing Provider also the Rendering Provider?
- Question: Is this service the result of a referral?

Subscriber/Client Information

- Client ID number
- Question: Is this a Medicare Crossover Claim?

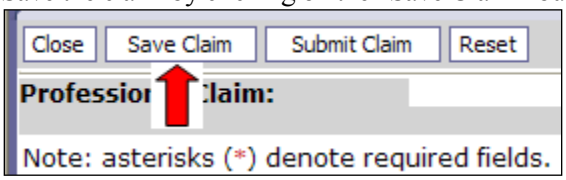
Claim Information

- Question: Is this claim accident related?

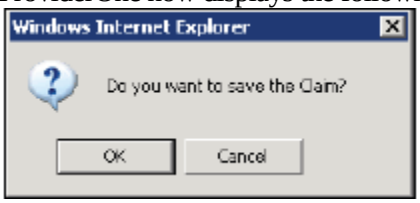
Basic Service Line Items

- Line Items are not required for saving a claim.

Save the claim by clicking on the "Save Claim" button.



ProviderOne now displays the following confirmation box:

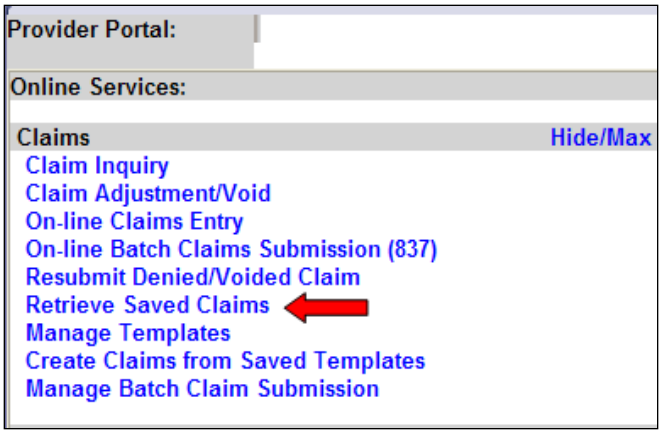


Click the OK button to proceed or Cancel to return to the claim form.

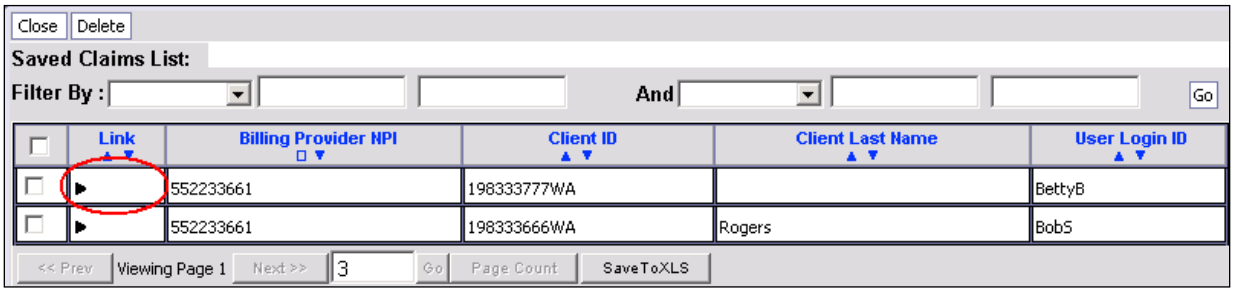
Once the OK button is clicked, ProviderOne checks the claim to make sure the minimum data fields are completed.
If all data fields are completed, ProviderOne saves the claim and closes the claim form.

Retrieving a Saved Claim

At the Provider Portal, click on the "Retrieve Saved Claims" hyperlink



ProviderOne displays the **Saved Claims List**.
Click on the **Link Icon** to retrieve a claim.

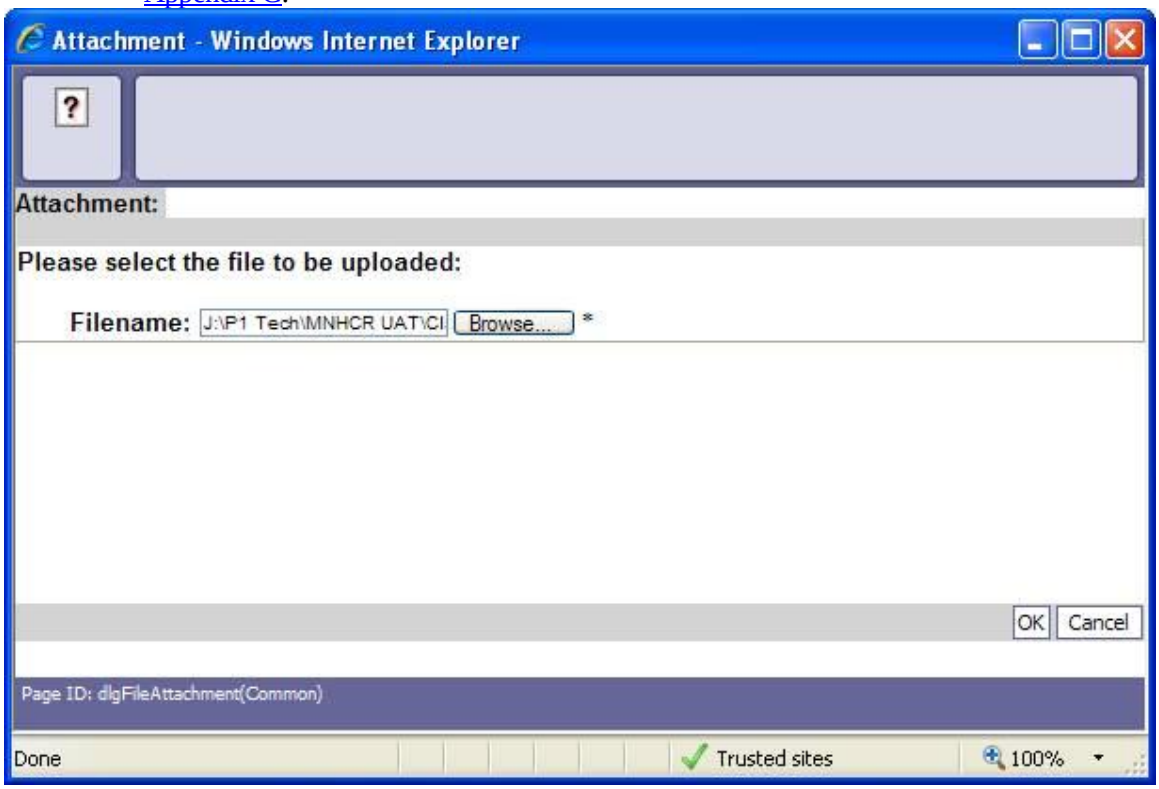


The system loads the saved claim in the Professional DDE screens. Continue to enter data, then submit the claim.
Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claim List.

3d. Online Batch Claims Submission

From the homepage, click on online batch claims submission

- Click on the **Submit HIPAA Batch Transaction** hyperlink.
- Click on the Upload button on the next screen.
- Click on Browse and locate the batch file.
- When the file name is displayed, click on the OK button
- If the upload was successful, ProviderOne displays a confirmation page – print this out and use it for reference when checking on the Batch Response (997).
- If sending in backup documentation to a claim in the batch (a TCN is required to do this), a completed and printed cover sheet is required. Cover sheets can be located at http://hrsa.dshs.wa.gov/download/Index.htm. For more information on cover sheets, please visit Appendix G.



HIPAA HINTS

COMMENTS ON BATCH CLAIMS

ProviderOne has a feature that allows comments to be scanned directly into the system, without the need of a worker to manually review the claim.

To make any of the following comments, put "**SCI=**" and the corresponding letter on the list below:

- **B** – BABY ON MOMS CLIENT ID
- **F** – ENTERAL NUTRITION – CLIENT NOT ELIGIBLE FOR WIC
- **H** – CHILDREN WITH SPECIAL HEALTHCARE NEEDS
- **I** –INVOLUNTARY TREATMENT ACT (ITA) (Legal Status)
- **K** – NOT RELATED TO TERMINAL ILLNESS (Hospice Client)
- **V** – VOLUNTARY TREATMENT (Legal Status)

- **Y**– SPENDDOWN AMOUNT (and list the amount) **(837P only)**

BILLING MEDICAID AS THE SECONDARY PAYER USING HIPAA BATCH FILES
Providers can use an 837 transaction to electronically submit to the Agency the primary payer insurance information. Please follow the guidelines within the ProviderOne 837 Professional, Institutional and Dental Companion Guides at http://hrsa.dshs.wa.gov/dshshipaa/

837 Professional (Pages 40-45, 52-53)
837 Institutional (Pages 80-84, 90-91)
837 Dental (Pages 112-116, 122-123)

Avoid sending in back-up documentation from the primary insurance by 1) adding the comment "electronic TPL" in the remarks field (Loop 2300 NTE Segment), AND 2) send in the appropriate adjustment reason code information about the action the primary payer took within the appropriate loops and segments.

3e. Paper

Guidelines/Instructions for Paper Claim Submission:

- In order for the claim to be read by the Optical Character Reader (OCR) feature of the scanner, the blank claim form must be a commercially produced form with:
  - Either Sinclair Valentine J6983 or OCR Red Paper using these scannable red inks. These inks cannot be duplicated by a computer printer.
  - Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid, or tape anywhere on the claim form or backup documentation. The red ink will not be picked up in the scanning process and the highlighter could turn into a dark square covering the highlighted information.

- Use standard typewritten fonts that are 10 C.P.I (characters per inch).
  - Do not mix character fonts on the same claim form.
  - Do not use italics or script.

- Use black printer ribbon, ink-jet, or laser printer cartridges.
  - Make sure ink is not faded or too light.
  - Use of Dot Matrix printers may compromise the print quality.

- Ensure all the claim information is entirely contained within the proper field on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- For multiple page claims, please designate the page number on each page in the lower right hand corner. Put this information (e.g. 1 of 5, 2 of 5, 3of 5, etc) in the white space at the very bottom of the claim form. This will help multiple page claims from being separated. The total dollar amount needs to be on page one for all combined pages. You can leave the subsequent totals blank.

See Appendix I for detailed instructions on filling out the CMS-1500 claim form.
See Appendix J for detailed instructions on filling out the UB-04 claim form.
See Appendix K for detailed instructions on filling out the 2006 ADA claim form.

Providers should submit their paper claims to the following address:

All Paper Claims
Medical Assistance, attn: Claims
PO Box 9248
Olympia, WA 98507-9248

Note: The Agency will not accept hand written claim forms. In addition, copied claim forms will not be accepted.

Note: For electronic billers, all data elements required on a paper claim form are the same on the electronic billing. Use the Appendix(s) as a data element location reference.

Pitfalls

- **Failing to use the National Provider Identifier (NPI) that the Agency has on file. This can cause the claim to be denied.**
- **Failure to use a proper taxonomy code. This can cause the claim to be denied.**
- **Failure to include gender on the claim. This can cause the claim to be denied.**
- **Highlighted information on the paper claim form. This may cause vital data to not be recognized in the OCR process, resulting in possible claim denial.**
- **Using stamps, stickers, or comments that say, "REBILL," "TRACER," or "SECOND SUBMISSION" or similar statements on any claim. These notes cannot be processed.**
- **Failing to indicate the baby's name, birth date and gender on a newborn claim using mom's ID. This can cause the claim to be denied.**
- **Forgetting to hit the "OK" button on the bottom of the last pop-up on the DDE screens. If a claim is submitted DDE and the system assigned it a TCN, but the TCN cannot be found in the system, the submitter forgot to click the final "OK" button on the bottom of the last pop-up screen. Do not exit out of this pop-up as exiting out will result in the claim not being submitted.**
- **Failure to turn off the pop up blocker when using ProviderOne. The submitter will not be able to finish submitting a Direct Data Entry claim if the pop up blockers are turned on.**
- **Forgetting to hit the "Enter" key or to click outside any field when filling out the cover sheet. The cover sheet will not then contain the proper barcodes and the back up will not be attached to the DDE claim in ProviderOne.**
- **Saving a filled out cover sheet. Do not save used cover sheets, as each cover sheet has unique coding for the claim the backup documents are to be attached to.**
- **Submitting paper claims. Electronic claims process much faster than paper claims.**

Key Step
4

4. Submit Medicare Crossover Claims

Why

"Medicare Crossover Claims" are claims for the client's Medicare cost sharing liability (deductible, coinsurance, or copay). Claims denied by Medicare are not crossover claims and this key step does not apply to these non-crossover claims.

This key step covers how crossover claims are submitted to and processed by the Agency. Managed Medicare claims (Medicare Part C or Medicare Advantage) should also be billed as crossover claims. Please use the instructions in this key step when billing Managed Medicare claims.

How

In most cases, after processing the claim for payment, Medicare will forward the claim electronically to the Agency and include a message on your Explanation of Medicare Benefits (EOMB) stating: "This information is being sent to either a private insurer or Medicaid." The Agency then processes these crossover claims without any action on the provider's part.

Sometimes Medicare does not forward claims automatically to the Agency, so providers may have to bill the crossover claim directly to the Agency. Paper crossovers submitted directly to the Agency will require a copy of the EOMB.

The Agency recommends billing claims electronically or using ProviderOne DDE for faster processing. DDE crossovers claims do not require the EOMB.

Providers will know if Medicare has not forwarded the crossover claim to the Agency if:

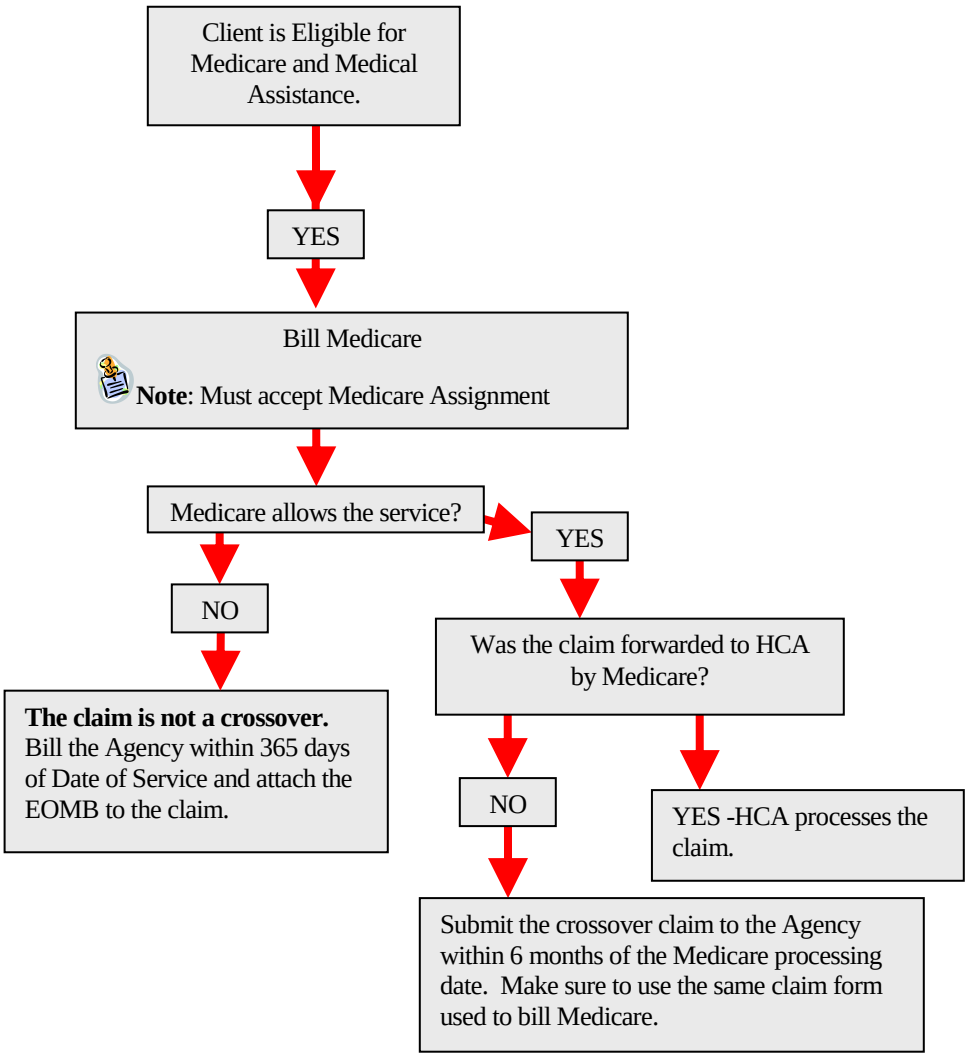
- It does not show up on the Medical Assistance Remittance Advice; or
- The message "This information is being sent to either a private insurer or Medicaid" does not show up on the EOMB.

Some of the reasons Medicare may not forward a crossover claim directly to the Agency include:

- The patient may be a new Medicare/Medicaid enrollee and Medicare does not yet list them as having Medicaid coverage.
- The provider billed Medicare with an NPI number that has not been reported to the Agency.
- There are Electronic file corruption issues.
- Managed Medicare (Medicare Part C or Medicare Advantage Plans) may not forward claims directly to the Agency

See Appendix M for payment methodology information on crossover claims.

Overview of Medicare Crossover Process



The next section explains how each type of Medicare crossover claim is submitted to the Agency if the claim is not automatically forwarded by Medicare. Please see Appendix M for crossover payment methodologies.

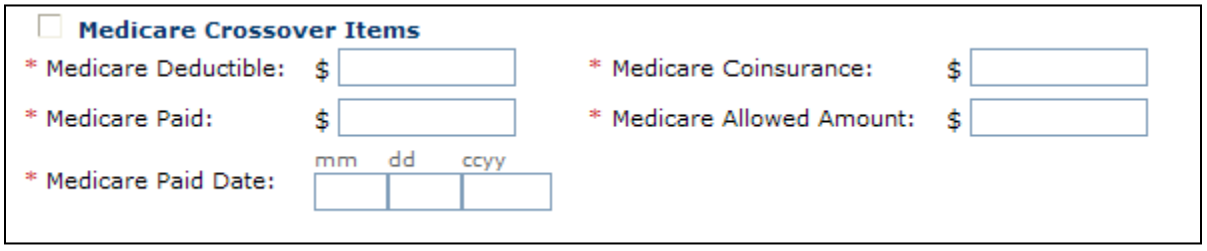
Medicare Part B Professional Services (CMS-1500, 837P)

- If Medicare has paid all lines on the claim, submit the crossover claim to the Agency.
- If Medicare has allowed and denied services lines on the claim, do not submit paid lines with denied lines to the Agency on the same claim form; this could cause a delay in payment or claim denial. Submit 2 claims to the Agency - one crossover claim for services Medicare paid and one professional claim for services Medicare denied.

- If Medicare denies a service that requires **PRIOR** authorization (PA) by the Agency, the Agency waives the **PRIOR** requirement but still requires authorization based on medical necessity, which may be requested after the service is provided.
- Bill the Agency on the same claim form billed to Medicare with the same services and billed amounts.
- Bill Medicare with the appropriate Agency taxonomy code for the claim according to Medicare guidelines. Medicare will then forward the taxonomy on the claim to the Agency.
- If billing DME rental codes that require a date span, please bill Medicare with the appropriate date span. Medicare will then forward the date span on the claim.

When submitting a Direct Data Entry (DDE) professional services crossover claim in ProviderOne, fill out the additional Medicare information at the line level for each line:

- Click the expander to open the "Medicare Crossover Items" fields. This includes Managed Medicare (Medicare Advantage Plans Part C).
- Fill in the Medicare information required in the now open fields then;
- The rest of the claim form is filled out per normal.



Note: If the Medicare Advantage or Part C Plan indicates an allowed amount for the service but does not make a payment on the service, enter the

- Copayment; or
- Coinsurance; or
- Patient Responsibility

as the deductible if the plan EOB indicates a remark code of copayment for the service. ProviderOne requires a deductible amount in this case to process the claim.
Example EOB:

DATES OF SERVICE	SVC PROVIDED/PPS	BILLED AMOUNT	ALLOWED AMOUNT	PAID AMOUNT	PATIENT LIABILITY	DISALLOWED AMOUNT	EOP CODES
120710-120710	99212	60.00	39.23	0.00	39.23	20.77	3 45
CLAIM TOTAL:		60.00	39.23	0.00	39.23	20.77	
SUMMARY TOTAL:		60.00	39.23	0.00	39.23	20.77	

EXPLANATION OF CODES

3 Co-payment Amount

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Note: If you bill a crossover electronically or DDE, the Agency does not require the EOMB.

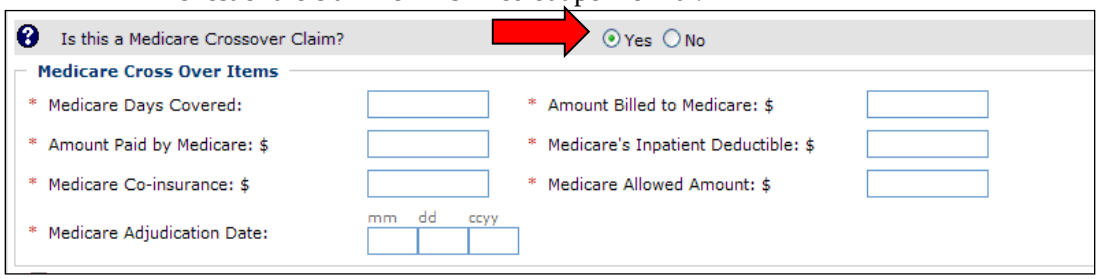
Medicare Part A Institutional Services (UB-04, 837i)

A provider that bills Medicare (or the Medicare Part C Plan) on the UB-04 claim form bills the Agency crossover claims on the same claim form. Include the same services and billed amounts sent to Medicare and attach the Medicare EOB to paper claims. A provider can:

- Submit DDE crossover claims in ProviderOne. DDE claims do not require the EOB.
- Send in paper claims with the EOB. Electronic claims (HIPAA batch and DDE) process much faster than submitting paper.

When submitting a DDE institutional crossover claim in ProviderOne, fill out the additional Medicare information at the claim level:

- Click the Radio button "yes" (Yes) to indicate this claim is a crossover
- Fill in the Medicare information required * in the now open fields then;
- The rest of the claim form is filled out per normal.



Note: While claims for clients that do not have Medicare Part A or Part A benefits are exhausted are not considered **crossover claims**, we have included how to bill these claims in this section.

How Do I Bill for Clients Covered by Medicare Part B Only (No Part A), or Has Exhausted Medicare Part A Benefits Prior to the Stay?

Description	DRG	Per Diem	RCC	CPE	CAH
Bill Medicare Part B for qualifying services delivered during the hospital stay.	Yes	Yes	Yes	Yes	Yes
Bill the Agency for hospital stay as primary.	Yes	Yes	Yes	Yes	Yes
Show as noncovered on the Agency 's bill what was billed to Medicare under Part B.	Yes	Yes	Yes	Yes	Yes
Expect the Agency to reduce payment for the hospital stay by what Medicare paid on the Part B bill.	Yes	Yes	No	No	No
Expect the Agency to recoup payment as secondary on Medicare Part B bill*.	Yes	Yes	No*	No*	No*

* The Agency pays line item by line item on some claims (RCC, CPE, CAH). The Agency does not pay for line items that Medicare has already paid. The Agency pays by the stay (DRG claims) or the day (Per Diem) on other claims. The Agency calculates the payment and then subtracts what Medicare has already paid. The Agency recoups what it paid as secondary on the Medicare claim.

Medicare Advantage Plans (Part C)

Some Medicare clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C) and providers are required to bill these Medicare Advantage Plans instead of FFS Medicare. The Managed Medicare – Medicare Advantage Plan is the primary payer and is not considered commercial insurance by the Agency.

- In order to receive payment from the Agency, it is necessary to follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing the Agency.
- After the Medicare Advantage plan processes the claim, submit the claim to the Agency as a Medicare crossover claim. Bill the Agency with the same claim type used to bill the Medicare Advantage plan. Make sure the services and billed amounts match what was billed to the Medicare Advantage plan. Direct Data Entry (DDE) claims do not require the EOB to be sent with the claim.
- The Agency must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.
- If Medicare Advantage denies a service that the Agency requires **PRIOR** authorization (PA) for, the the Agency waives the **PRIOR** requirement but will require authorization which may be requested after the service is provided. The the Agency waives the "prior" requirement in this circumstance.

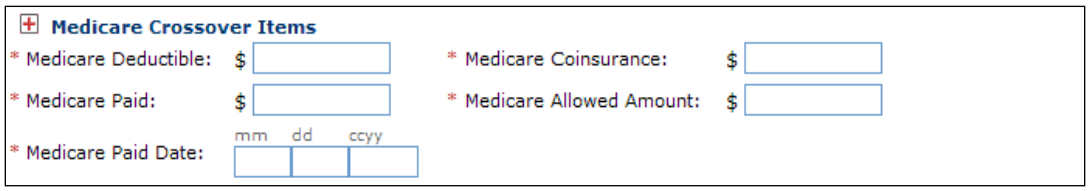
Billing for Managed Medicare – Medicare Advantage (Part C) Plans

If there is a capitated Copayment due on a claim:

Claims for Capitated copayments for the Medicare Part C Plan must now be billed as a crossover claim type (professional and institutional claims).
If no "Medicare (plan) Allowed Amount" is provided, enter the sum of:

- Payment + Copayment + Coinsurance + Deductible

as the "Medicare Allowed Amount". If there is no amount for an entry, just add together the entries that do have an amount.



- Finish filling in the other amounts (even if they were used to calculate an allowed amount).
- Enter a zero (0) in any other fields without a value.
- If the user entered a zero (0) in the "Medicare Paid" field, then enter the Co-pay amount in the "Medicare Deductible" field as ProviderOne requires a deductible if the plan allowed the service but pays at zero (0).

Comments are no longer required on the claim.

If there is coinsurance, a deductible, or a noncapitated copayment due on a claim:

If a balance is due for services provided:

- Bill the claim paid by the Part C Plan as a cross over claim.
- If the Medicare Advantage or Part C Plan indicates an allowed amount for the service but does not make a payment on the service, enter the
  - Copayment; or
  - Coinsurance; or
  - Patient Responsibility

  as the deductible if the plan EOB indicates a remark code of copayment for the service. ProviderOne requires a deductible amount in this case to process the claim. See above for an example of a Plan EOB.
- If Medicare Advantage has allowed and denied services lines on the claim, do not submit paid lines with denied lines to the Agency on the same claim form; this could cause a delay in payment or claim denial. Please submit 2 claims to the Agency, one crossover claim for services Medicare paid and one professional claim for services Medicare denied.
- If Medicare Advantage denies a service on a claim, the Agency may or may not make a payment on the service, depending on the reason for the Medicare Advantage Plan denial.

QMB – Medicare Only Clients

- If Medicare or the Part C Plan and Medical Assistance cover the service, the Agency pays only the client's cost sharing liability (deductible, and/or coinsurance, and/or copayment) up to the Medical Assistance allowed amount. Payment is based on the Medical Assistance allowed amounts minus any prior payment made by Medicare or the Medicare Advantage Plan. At this point the Agency considers the claim paid in full.

- If Medicare or the Medicare Advantage Plan does not cover the service, the Agency does not pay for the service.

Note: Discrepancies, disputes, protests, or justifications for a higher fee or payment for any claim should be directed to Medicare or the Medicare Advantage plan. If Medicare or the Medicare Advantage Plan adjusts the payment and the claim has previously been paid, submit an adjustment request to the Agency. Submit a new claim if the original claim was denied

Medicare Prescription Drug Program

For more information on the Medicare Prescription Drug Program, Please review the Prescription Drug Program Billing Instructions.

Pitfalls

- **Billing Medicare with an NPI that has not been reported to the Agency. The Agency will not be able to identify the provider when these claims are forwarded by Medicare to the Agency.**
- **Submitting crossover claims on paper. Paper claims process slower than other claim submission methods.**
- **The claim form billed to Medicare does not match the claim form billed to the Agency. The claim will be denied.**
- **The coding and dollar amount billed on the claim to Medicare does not match the coding and dollar amount on the claim billed to the Agency. The claim will be denied.**
- **Failing to bill the paid Part C plan claim as a cross over claim type.**

Key Step
5

5. Inquire About the Status of a Claim

Why

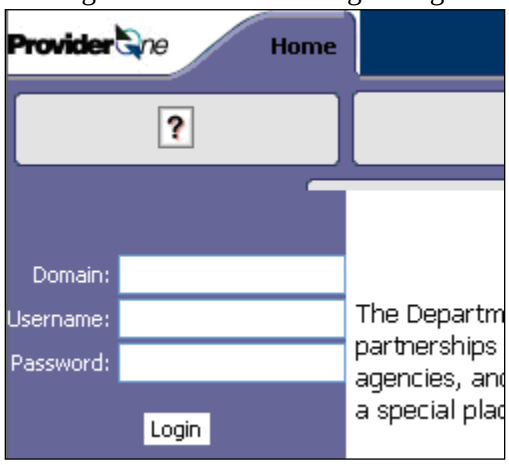
ProviderOne allows several options to search for a claim's status. A provider may want to check a claim because:

- A claim has been submitted and Medical Assistance has not responded.
- A provider is trying to re-bill some older claims and needs the Transaction Control Number (TCN) to prove timely submission of the original claim.
- A provider is searching for a claim because their accounts receivable system does not yet show a posted payment.

How

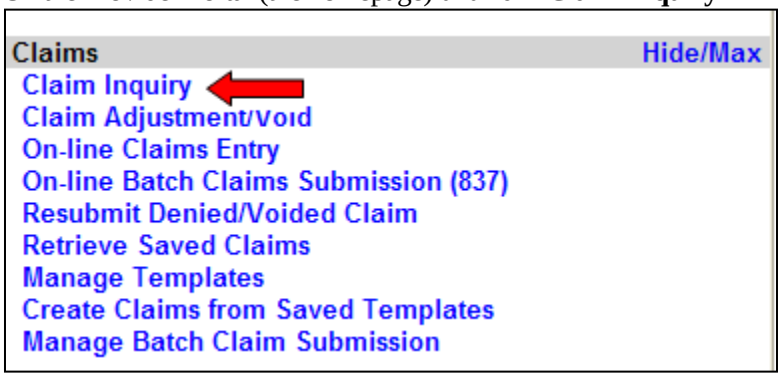
The easiest method to find claims in ProviderOne is to use the Claim Inquiry option at ProviderOne Home page option list.

- Log into ProviderOne using the log on information furnished by the office administrator.



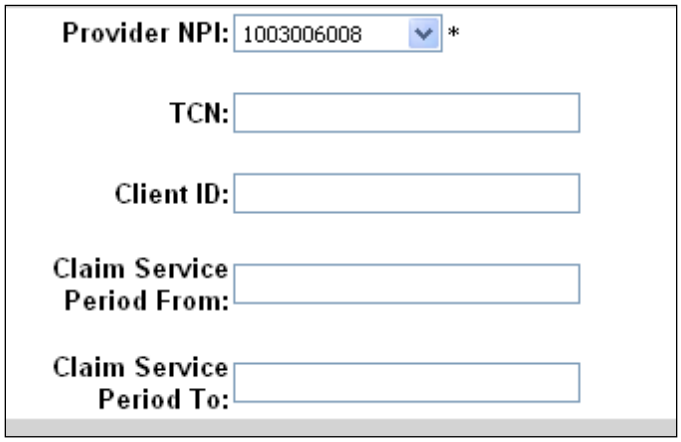
Select the **EXT Provider Claims/Payment Status Checker** or **EXT Provider Super User** profile .

On the Provider Portal (the homepage) click on "**Claim Inquiry**"



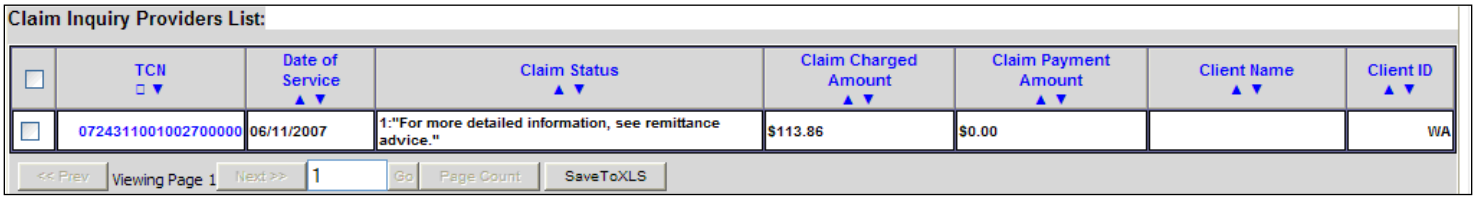
Select the appropriate NPI from the drop-down box and enter available information in the remaining fields before clicking submit.

- Required: TCN or Client ID and Claim service period (To date is optional).
- A provider may request status for claims processed within the past four years.
- The claim Service Period From and To date range cannot be greater than three months.



Note: To find a claim (or a list of claims) use the Client ID and the oldest "From" date of service on the claim. All claims for that date of service should be listed. Searching by the TCN only shows one claim and it may not be the one the provider is looking for.

After clicking on submit, the claim(s) list screen will be displayed. Click on the blue Transaction Control Number (TCN) hyperlink to view the claim



See Appendix N for instructions on checking claim status via the Interactive Voice Response (IVR).

Pitfalls

- **Calling the Medical Assistance Customer Service Center to check on the status of a claim. Providers can easily check on a claim status by using ProviderOne or the Interactive Voice Response (IVR).**

Key Step
6

6. Adjust, Resubmit, or Void a Claim

Why

The Agency does not process "corrected claims" so the only way to replace or correct a paid service or claim is through the claim adjustment process.

Adjust/Replace a paid claim when:
- A billing error was made (e.g., wrong client, billed amount, tooth number, etc).
- The claim contained multiple surgical procedure codes, and one of the procedures was denied or paid incorrectly.
- The claim was overpaid (this may be a void claim)

Denied claims can be resubmitted using the ProviderOne resubmit feature and fixing the error that caused the original denial. Providers also have the option to re-bill a denied claim fixing the original denial error.
ProviderOne will not allow adjusting a denied claim and a claim void will not remove the claim from the system.

How

Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 24 months from the date of service (WAC 182-502-0150). A timely claim is one that meets the Agency current initial timeliness standard which is 365 days from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

There are various methods to modify, adjust, or void claims depending on the billing format (HIPAA, DDE, paper):
- If the claim was paid or partially paid then an adjustment to the claim will be needed in order to make any corrections or modification to the original claim.
  - DDE - Log into ProviderOne, select the **EXT Provider Claims Submitter** or **EXT Provider Super User** profile, and use the online Claim Adjustment/Void option or
  - Fill out the paper claim form indicating an adjustment or a void (see below) or
  - Submit a HIPAA batch transaction claim using a frequency 7 to adjust/replace the original claim or a frequency 8 to void the original claim. Follow the ProviderOne companion guides rules for submitting frequency 7, adjust claim or 8, void claim transactions.

- If the claim was denied (no lines were paid) and no longer meets the initial 1 year timeliness rule, then proof of timely filing is required to resubmit.
  - Locate the timely TCN number using the ProviderOne claim status search option or review a Remittance Advice

- DDE claim, resubmit the original claim. If it is not possible to resubmit the original claim, enter the timely TCN number in the comments field of the new claim ("timely TCN 12345678901234567 8").
- HIPAA batch claim transactions. Follow the ProviderOne companion guides rules for entering the timely TCN number.
- Paper claims note the placement of timely TCN numbers in the following sections listing how to fill out each type of claim form.

Note: If a claim was originally paid then subsequently adjusted/replaced and paid and it is necessary to reprocess the claim for a third time (or fourth, fifth, etc) it will be necessary to adjust/replace the LAST TCN in the claim trail. Once a claim TCN has been adjusted it cannot be adjusted or resubmitted again.

The General Adjustment Process

The ProviderOne system assigns an 18 digit Transaction Control Number (TCN) to each claim received. This TCN is part of the information sent to providers on their Remittance Advice (RA), has its own column, and is commonly referred to as the "claim number".

Reading the TCN

Each of the 18 digits in the claim number has a reserved meaning representing the following:

1	0	08183	0	0000001	000
A	**B**	**C**	**D**	**E**	**F**

A: Claim Medium Indicator

- 0 – Not used
- 1 – Paper
- 2 – Direct Entry (Web Submission)
- 3 –Electronic (X12)
- 4 – System Generated
- 5-8 – Reserved

A **9** in the claim medium indicator field represents a claim that was billed in the Legacy (old payment) system. These TCNs are 21 digits long.

B: Type of claim

Placeholder number that could be on of the following:

- 0 – Medical
- 1 – Pharmacy
- 2 – Crossover or Medical
- 3 – Medical Encounter
- 4 – Pharmacy Encounter
- 5 – Social Services
- 6-9 – Reserved

C: Batch Date

- First two digits are the year (08)
- The next 3 numbers are the Julian day of the year with 183 being July 2nd. The Agency utilizes the Julian calendar to record the date claims were received. The Julian calendar is simply a continuous counting of the days of the year from 1 to 365. Remember Leap Years!

D: Adjustment Indicator

- 0 – Original Claim
- 1 – Adjustment (credit)

E: Claim Sequence Number

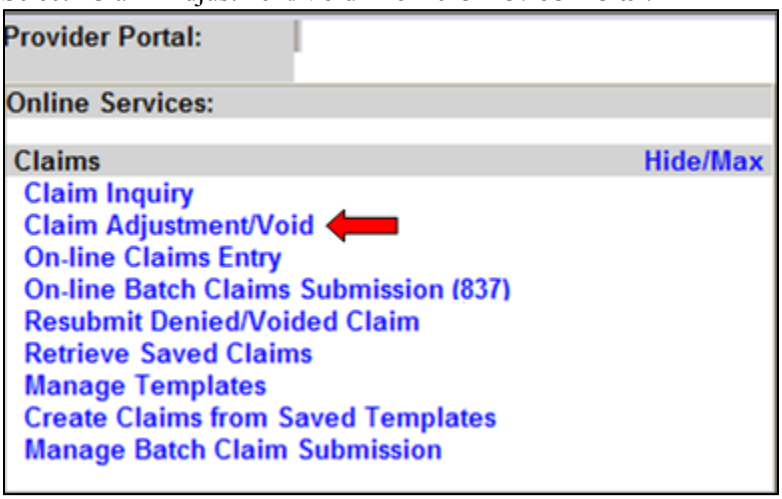
- Sequential counting of claims each day starting with 0000001
- Allows claim counting to reach almost 10 million, 9,999,999 claims daily

F: Line Number

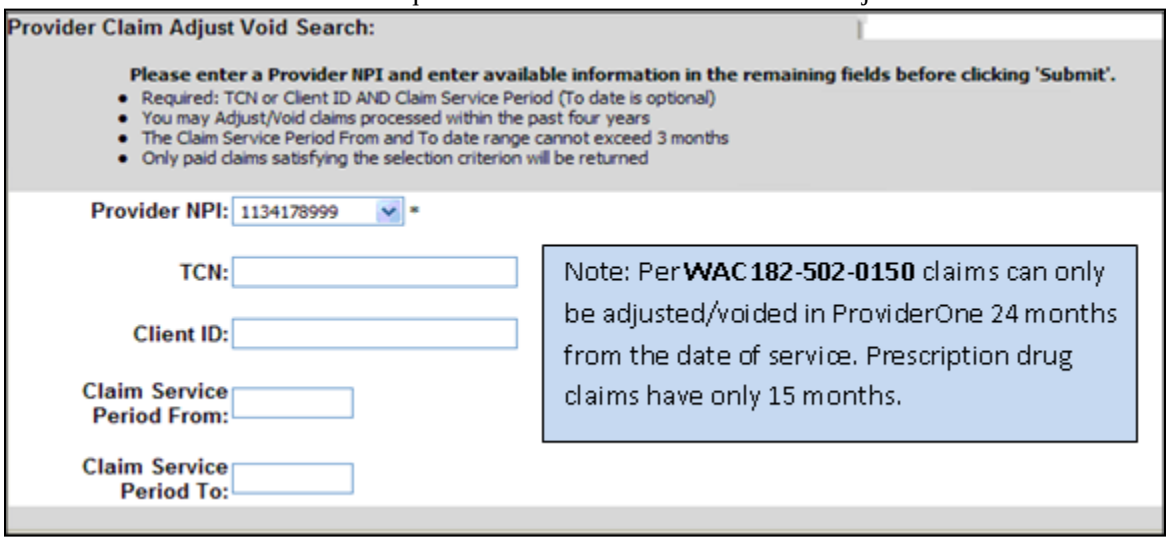
- The claim level number will be 000
- Each claim line also has a TCN number. The line number will start with 001 for each new claim line. (HIPAA Transactions can have up to 999 lines)

Adjust or Void a Paid Claim

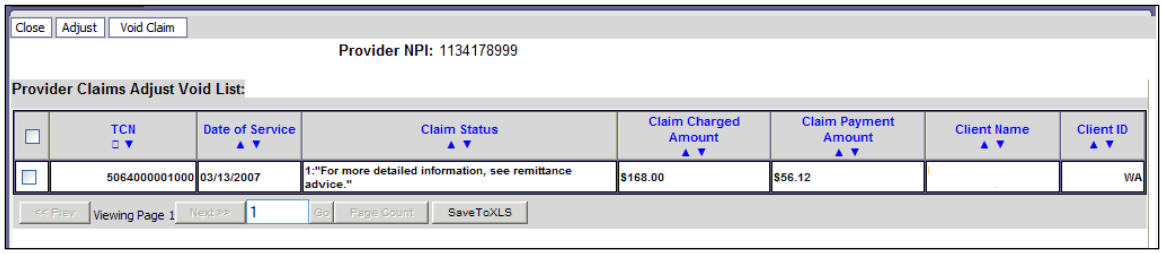
Select "Claim Adjustment/Void" from the Provider Portal.



At the search screen enter the required information to find the claim to adjust or void and click on submit.

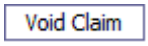


The system will then display claim(s) based on the search criteria.



Click on the box next to the TCN, then click the adjust Adjust button in the upper left hand corner. The claim will then be displayed in the DDE screen with the values of the selected claim filled in the data fields. Make the necessary changes then resubmit the adjustment request to Medical Assistance for

processing. The system will go thru the same final steps of a claim submission asking if back up is being sent, etc. Remember to click the "OK" button on the **Submitted Claim Details** screen to finish sending in the resubmitted claim! A different TCN will be assigned to the claim after it is resubmitted.

If the claim is being Voided click on the 

button in the upper left hand corner. The claim data will be displayed in the DDE screen but all the values will be grayed out and cannot be changed. Simply click the submit button and the void will be sent to Medical Assistance for processing and will show up as a credit on the RA.

Paper Adjustment/Void

- Enter the Transaction Control Number (TCN) found on the Remittance Advice (RA) in the appropriate box on the claim form. The adjustment/voids are done on the same claim form used for the initial billing. Complete the form with all the necessary claim information. See directions in the table below on how to adjust and void each claim type.

	Adjust/Replace a Paid Claim	**Void/Cancel a Paid Claim**
Professional Claims	Adjust a Professional claim (CMS-1500) by entering the qualifier 7 then the TCN in field #22 (Medicaid Resubmission Code). Example: 22. Medicaid Resubmission Code: 7 | Original Ref No.: 300629600000340000	Void a Professional claim (CMS-1500) by entering the qualifier 8 then the TCN in field #22 (Medicaid Resubmission Code). Example: 22. Medicaid Resubmission Code: 8 | Original Ref No.: 300629600000340000
Institutional Claims	To adjust or replace an institutional claim, submit 7 as the last digit of the Type of Bill. Put the TCN of the claim to adjust in form locator 64.	To void or cancel an institutional claim, submit 8 as the last digit of the Type of Bill. Put the TCN of the claim to adjust in form locator 64.
Dental Claims	Adjust a dental claim by entering the qualifier 7 then the TCN in field 35 (Remarks) Example: 7-300629600000340000	Void a dental claim by entering the qualifier 8 then the TCN in field 35 (Remarks) Example: 8-300629600000340000

Note for legacy adjustments –

If adjusting a claim that was billed in the legacy system, look up the new TCN to adjust in ProviderOne. If the legacy ICN to adjust is already known, convert it to the new TCN by putting a 9 in front of the ICN and 3 zeros at the end. These TCNs will be 21 digits. ProviderOne will not recognize legacy ICNs that are not converted to the new TCNs.

- Complete adjustments on the applicable claim form (CMS 1500. UB04 or ADA2006).
  - Use only one applicable claim form per claim.
  - Submit multiple line corrections to a single claim on one applicable claim form.
  - See special instructions on the following page if adjusting an overpayment.
  - Adjust the most recent claim in "paid status".

- Use the same process for Adjusting/Voiding a Medicare Crossover claim.

- Attach proper documentation to the adjustment request
  - Include operative reports (if needed for payment)
  - Insurance EOBs.
  - Medicare EOB
  - Any invoice or other documentation.

- Send the paper adjustment to the Agency
  - Mail to The Health Care Authority
    Division of Medical Benefits and Care
    PO BOX 9248
    Olympia, WA 98507-9248

- ProviderOne will locate the claim to adjust. The entire original claim will be credited (represented as minus amounts on the RA transaction) back to the Agency to allow the adjusted claim to pay correctly (represented as replacement amounts on the RA transaction). The Adjustment Reason Code 129 will appear in that column on the RA associated with the credit transaction.

- If a provider is voiding/canceling an overpayment claim, submit a void claim request
  - The Agency will recoup the claim and deduct the excess amount from a future remittance check(s) until the overpayment is satisfied;

OR

- Issue a refund check payable to the Health Care Authority
  - Attach a copy of the RA showing the paid claim and include a brief explanation for the refund.
- Mail to The Health Care Authority
  - Finance Division
    PO BOX 9501
    Olympia, WA 98507-9501

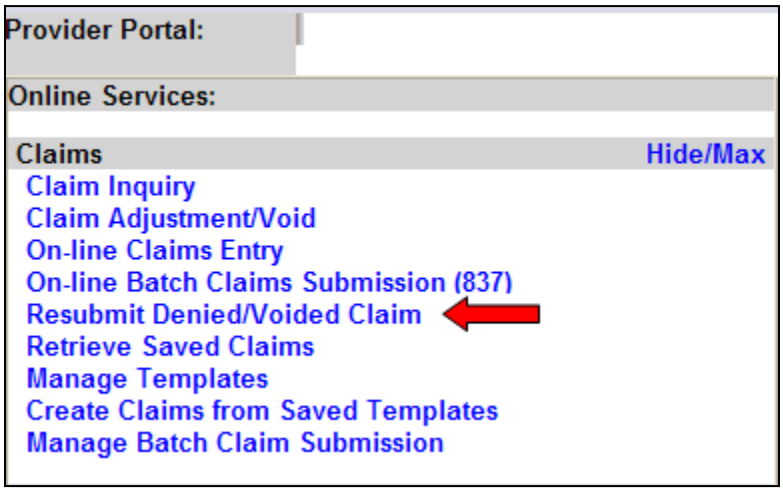
The billing time periods do not apply to overpayments that the provider must refund to the Agency. After the allotted time periods, a provider may not refund overpayments to the Agency by claim adjustment. The provider must refund overpayments to the Agency by a negotiable financial instrument such as a bank check. [Refer to WAC 182-502-0150 (8)]

Note: The adjusted/replaced claim will appear on the Remittance Advice (RA) in the adjustment claim section as two transactions, 1) the original claim and 2) the replacement claim. The claim paid amount would be adjusted accordingly based on the adjustment request and the adjusted amount would be reflected in the total payment. See section Reconcile the RA for a complete RA explanation.

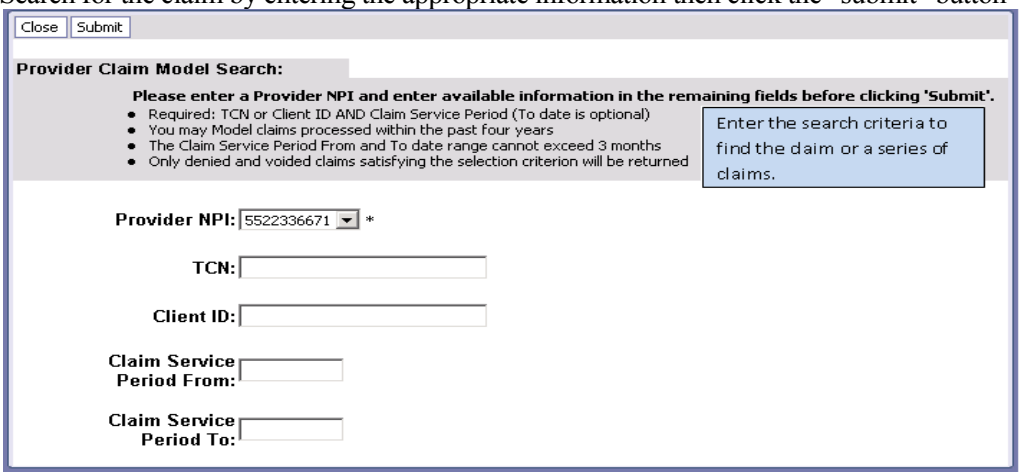
Note: When a claim is void/canceled the Agency will recover the amount originally paid from the next total payment and the voided claim will appear on the RA as only one transaction.

Resubmit A Denied Claim

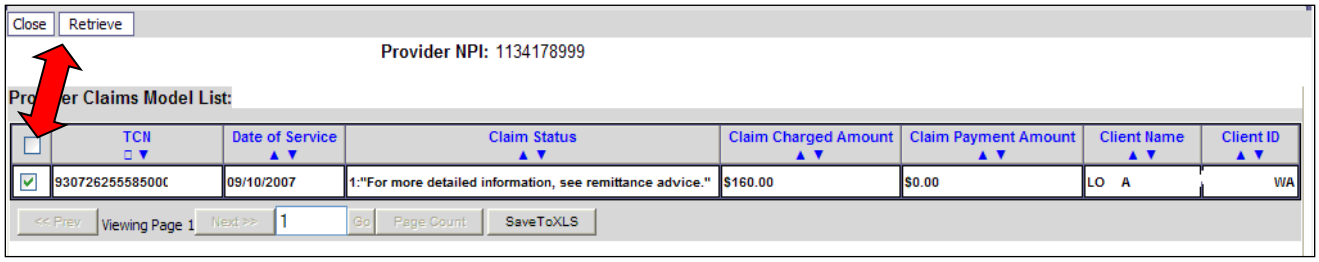
Select "Resubmit Denied/Voided Claim" from the Provide Portal main menu.



Search for the claim by entering the appropriate information then click the "submit" button



ProviderOne will display the claim list screen. Click on the box next to the TCN of the claim to be resubmited then click the "Retrieve" button in the upper left hand corner. The claim will be displayed in the DDE screen with the values of the selected claim in the fields and will indicate the type of claim.



Make any necessary changes to the claim using the same procedure as describe above in adjusting a claim section. When the changes are done submit the claim to Medical Assistance for processing.

The system will go thru the same final steps of a claim submission asking if back up is being sent, etc. Remember to click the "OK" button on the **Submitted Claim Details** screen to finish sending in the resubmitted claim! A different TCN will be assigned to the claim after it is resubmitted.

Pitfalls

- **Failing to include the TCN in the applicable field on the paper claim form adjustment request. This will cause the adjustment claim to be denied as a duplicate claim.**
- **Failing to indicate the TCN on the paper claim form adjustment. This will cause Medical Assistance to be unable to complete the request.**
- **Adjusting the wrong claim or claim line. This could result in unexpected results with the claim and payment.**
- **Failing to click the "OK" button on the Submitted Claim Details screen will result in the claim not being sent to Medical Assistance.**

Key Step
7

7. Creating a Template Claim

Why

ProviderOne allows a provider to create and save a template of a claim for services they may be billing for a client on a weekly, bi-weekly, or monthly basis. When creating a DDE template, the provider can add as much claim information to the template as they need or want however the system does require a minimum of information to be able to save the template. The minimum required information is:

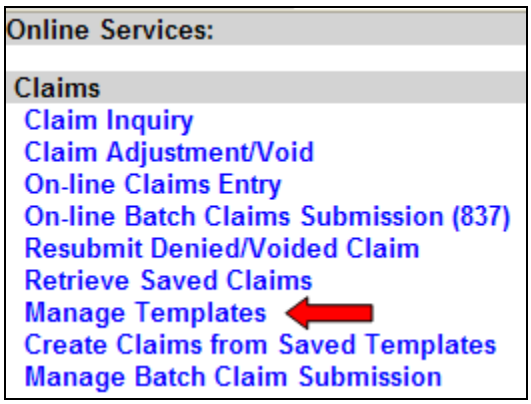
- A Template Name
- Answer the questions on the DDE screen
- If a closed data field is opened then additional information may be required

Once saved a template can be used to submit a claim and the template can be used over and over again to create claims. The template can be edited and resaved or deleted if no longer useful. Many templates can be created and saved. The next chapter is about submitting a template claim.

How

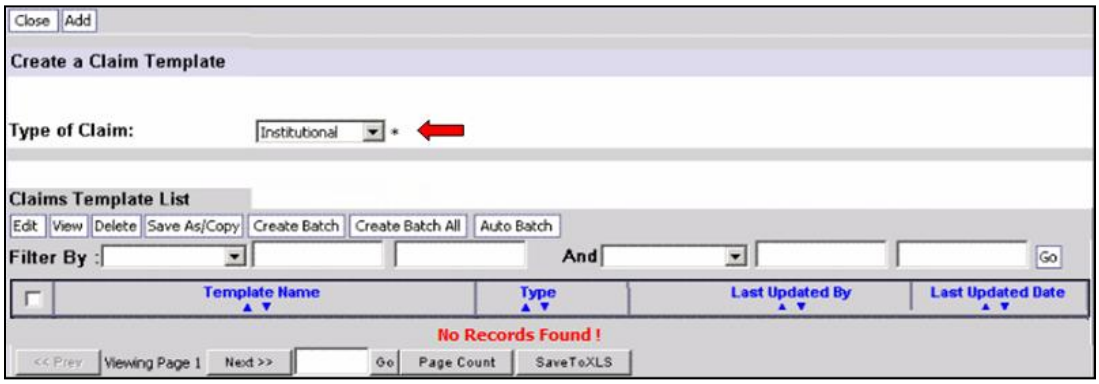
Create a template (s) using the DDE screens.

- Log into ProviderOne with the **EXT Provider Claims Submitter** or EXT **Provider Super User** profile.
- From the Provider Portal, click on the **Manage Templates** hyperlink



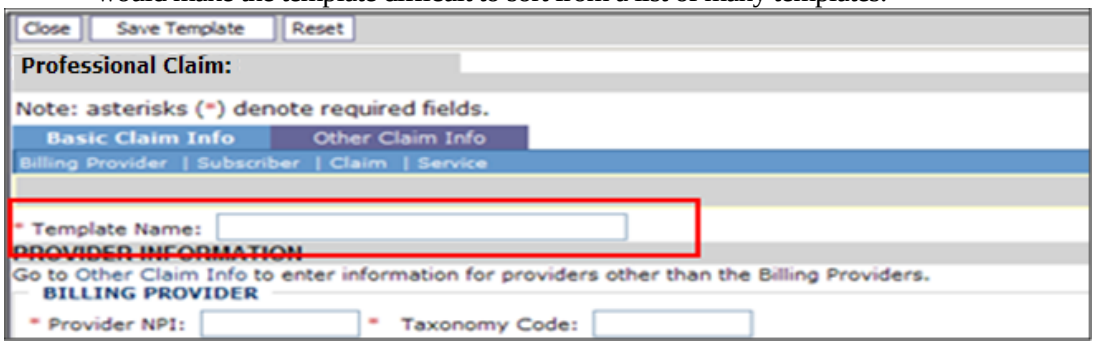
At the **Create a Claim Template** screen providers can perform many actions with a template.

Create a Template



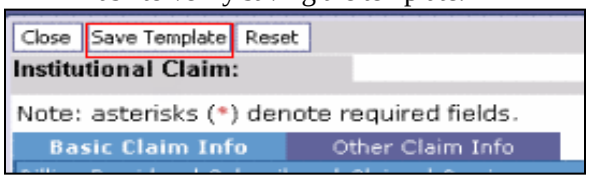
- First start building a template by choosing which type of template is desired then click on the **Add** button.

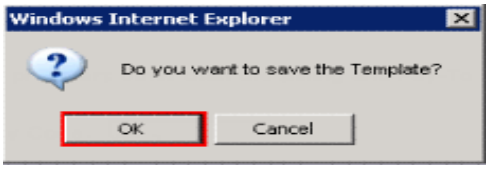
- Pick a name for the template. Use a name that describes a service or use the client's name. It is best not to use a template name that uses alpha/numeric characters that are common to all templates which would make the template difficult to sort from a list of many templates.



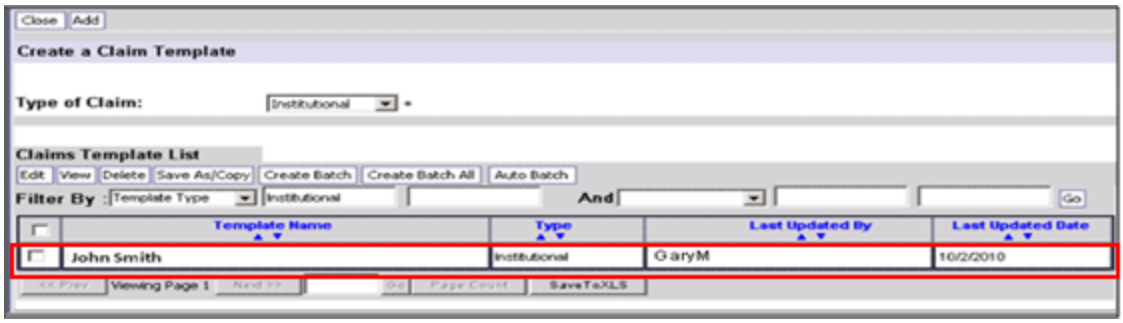
- Fill in as many data fields as possible. If the template is for a client that receives specific services monthly then fill in all fields except the dates of service. If the template is service specific then fill in all the service information and leave off the client information and dates of service.

- Once the template is complete and ready to save click on the **Save Template** button. The system will ask to verify saving the template.





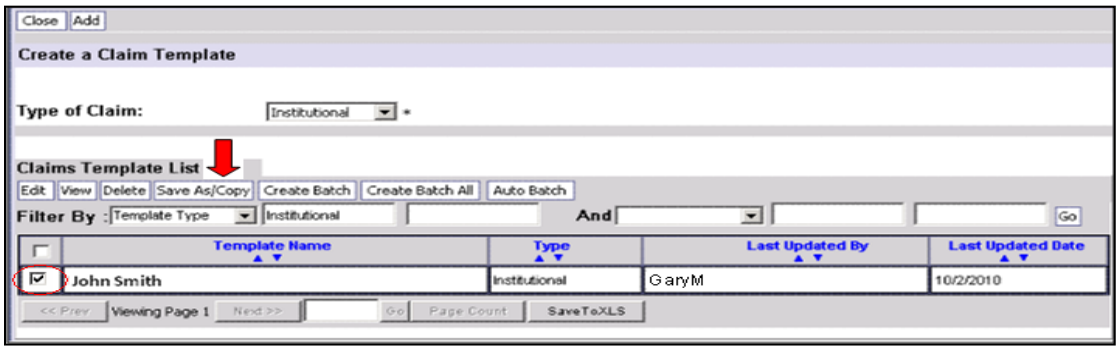
- After clicking the OK button, ProviderOne returns to the Claim Template screen adding the template to the list.



- Add as many templates as needed.
  - Create new ones using the above method or;
  - Copy the saved template then edit it

Copy a Template

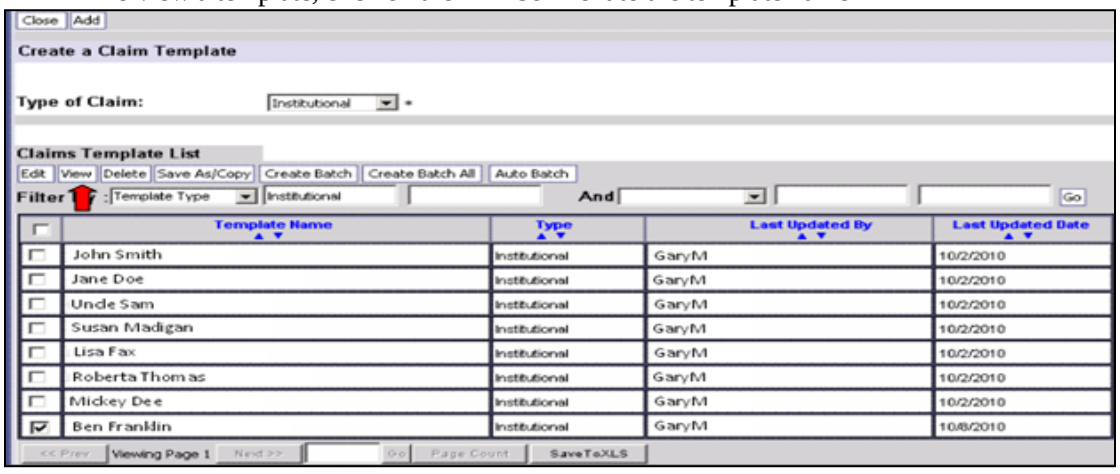
- To copy a template, click on the ☑ box next to the template name



- Then click on the **Save As/Copy** button
- The system now displays the DDE screen with the template information except the template name. Name this template and change any data as needed then save the template. Build as many templates as required using this method.

View a Template

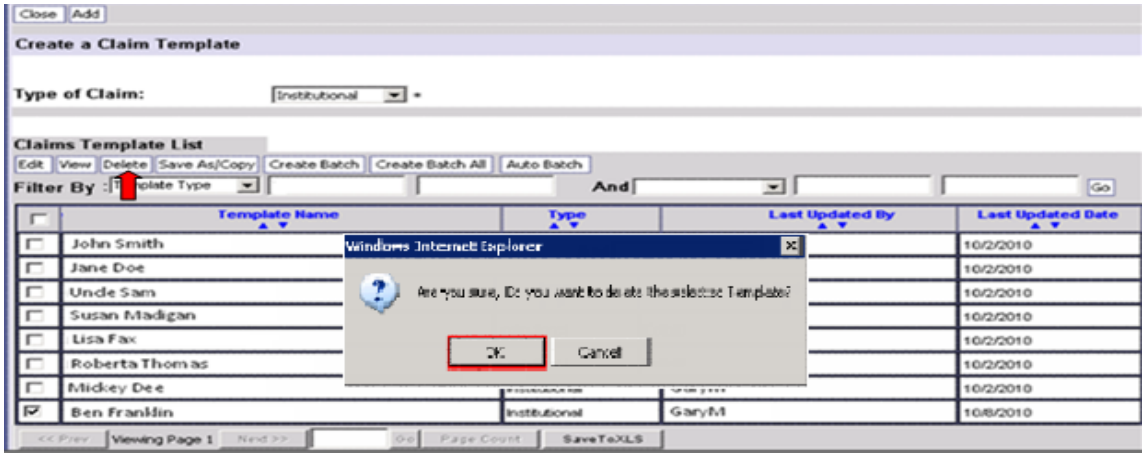
- To view a template, click on the ☑ box next to the template name



- Then click on the **View** button
- The system now displays the DDE screen with the template information and all the template data is grayed and cannot be edited.

Delete a Template

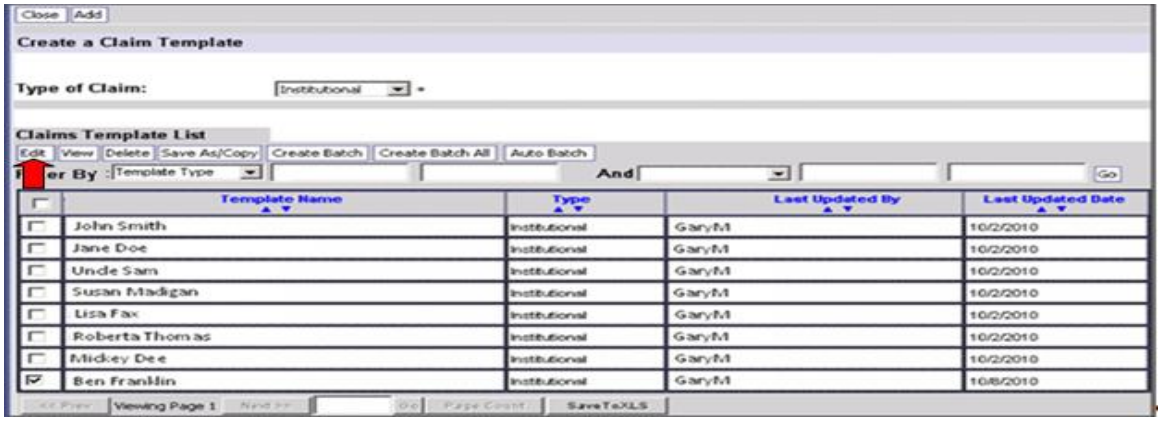
- To delete a template, click on the ☑ box next to the template name



- Then click on the **Delete** template button
- Clicking on the OK button deletes the template

Edit a Template

- To edit a template, click on the ☑ box next to the template name



- Then click on the **Edit** button
- The system now displays the DDE screen with the template information available to edit and be changed or updated as needed.

Note: When building and saving a template ProviderOne will ignore some of the system rules i.e. not all asterisk (required) fields need data entered.

Pitfalls

- **Choosing the wrong profile after logging into ProviderOne.**
- **Choosing the wrong claim type for the template.**
- **Using common starting characters in naming the template. Makes it difficult to sort to find a template on a large list.**

Key Step
8

8. Submitting a Template Claim or a Batch of Template Claims

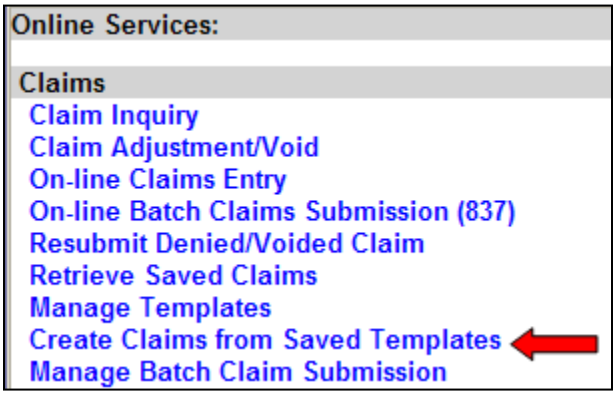
Why

Providers that bill reoccurring services for a client or clients may want to use a claim template to create and submit those claims.
ProviderOne also allows certain provider types to build batches of templates into a batch of claims instead of submitting a single claim template one at a time.

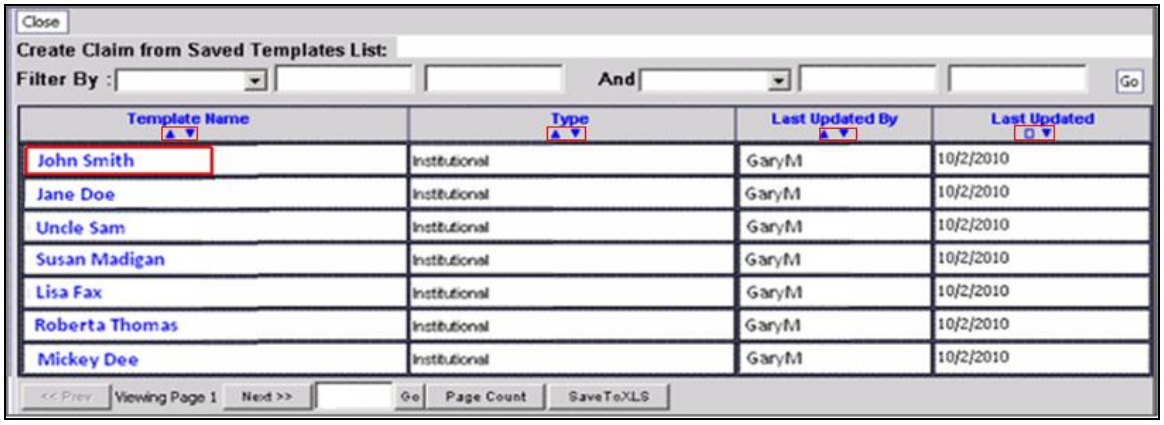
How

Submit a Single Claim from a Template

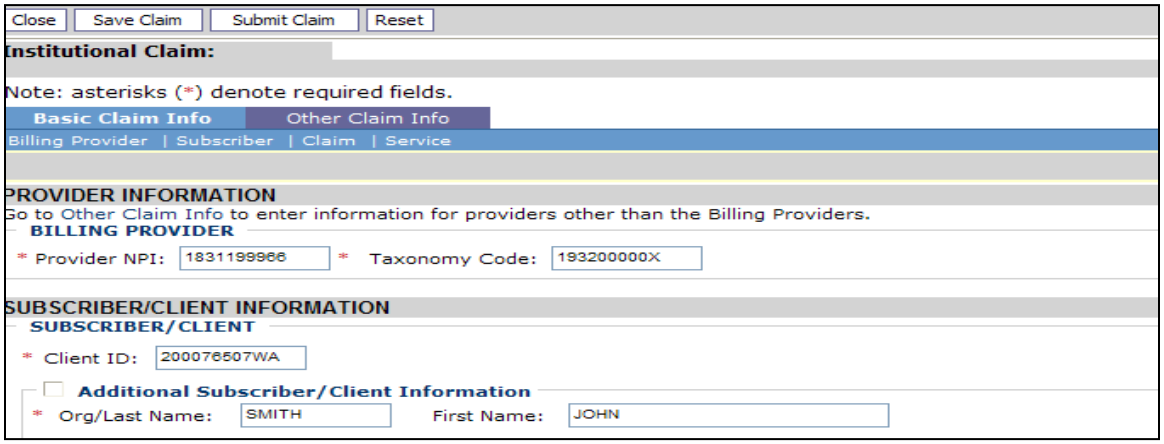
- Log into ProviderOne with the **EXT Provider Claims Submitter** or **EXT Provider Super User** profile.
- From the Provider Portal, click on the **Manage Templates** hyperlink



- ProviderOne should display the **Create Claim from Saved Templates List** screen.



- The list of templates can be sorted if it is huge by a couple of methods:
  - Use the Filter By boxes to find a specific template or;
  - Use the sort tool (little diamonds) under each column title which sort from top to bottom or bottom to top.
- Click on the template name hyperlink which loads the template in the DDE screen.



- At the DDE screen finish filling in the claim data.
- Once all the data is entered the claim can be saved or submitted to ProviderOne.
- If submitting the claim, ProviderOne will ask if back up is being sent. If sending back up complete that process.
- Click on the OK button to submit the claim.
- Go back to the **Create Claim from Saved Templates List** screen if another claim needs to be submitted using a template.

Submit a Batch of Template Claims

ProviderOne has the ability to identify and gather a group of claim templates together to create a batch of templates for submission into the system as a batch of claims. This process has these basic requirements:

- All claim types must be the same in the batch(i.e. professional, dental, or institutional)
- All batch templates will be for the same date of service (or date span)
- The billed amount could be the same on each claim template (based on the date(s) of service)
- Each claim template units will be the same (calculated based on the date(s) of service)

A detailed explanation of the process is beyond the capacity of this publication however the **ProviderOne Managing Claims s**ystem manual has a complete overview of the process. Nursing Home providers submitting Institutional claims have a detailed webinar and presentation slide show demonstrating the complete process. Other provider types wanting to use the process would follow the same steps however they may be using a different claim form.
The basic process outline includes:

- Log into ProviderOne and go to **Manage Templates**
- At the **Claims Template List** screen there are 3 options to create a batch of claim templates:
  - Create Batch
  - Create Batch All
  - Auto Batch
- At the **Batch Claim Attributes** screen assign the From-To dates of service then build the batch
- Each batch is assigned a batch number
- Now at the portal page switch to the **Manage Batch Claim Submission** hyperlink
- At the **Batch Claim Submission Status List** page check the status of a batch. Status can be:
  - Waiting
  - In Process
  - Failed in Validation
  - Passed Validation
  - Submitted for Claims Loading
- Only template batches that have **Passed Validation** can be submitted as claims
- Submitted **Passed Validation** batches are now in **Submitted for Claims Loading** status. Claims are assigned a TCN and start processing in ProviderOne. This template batch is then auto purged from the list page.

Pitfalls

- **Forgetting to change a data element that needed changing on a template. Could result in a denied claim or an overpaid claim.**
- **Trying to submit a batch of templates that are different claim types.**
- **Not keeping track of the batch number for specific template batch service.**
- **Trying to submit a batch of templates that have not passed validation.**

Appendix I: Completing Claim Form CMS 1500

The 1500 Claim Form is a universal claim form and is the "approved" form that must be used when billing for professional services. Approved forms will say "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom right hand corner. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing the Agency. Some field titles may not reflect their usage for a particular claim type.

Field	Name	Action
1a	ProviderOne Client ID	Enter the ProviderOne Client ID (example 123456789WA).
2	Patient's Name	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility. If billing for a baby on mom's ID enter the baby's name here. If the baby is un-named use the mom's last name and "baby" as the first name.  **Note:** be sure to insert commas separating sections of the name!
3	Patient's Birthdate Patient's Sex	Enter the client's birthdate in the following format: MMDDCCYY. Do not include hyphens, dashes, etc. Enter the patient's sex (gender). If billing baby on mom's ID enter the baby's birth date instead. If billing baby on mom's ID enter the baby's sex here.
4	Insured's Name	When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, TRI-CARE, or TRI-CAREVA) enter the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word Same may be entered.
5	Patient's Address	Enter the address of the client who received the services (the person whose name is in Field 2.)
6	Patient Relationship to Insured	Check the appropriate box.
7	Insured's Address	Enter the address of the insured.
9	Other Insured's Name	If there is other (primary) insurance (Field 11d), enter the last name, first name and middle initial of the person who holds the other insurance. If the client has other insurance and this field is not completed, payment of the claim may be denied or delayed.
9a	Other Insured's Policy or Group Number	Enter the other insured's policy or group number.
9b	Other Insured's Date of Birth and Gender	Check the appropriate box for the insured's gender and enter the birthdate in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
9d	Insurance Plan Name or Program Name	Enter the insurance plan name or program name (e.g., the insured's health maintenance organization, private supplementary insurance). Please note: Medical Assistance, Medicaid, Welfare, Provider Services, Healthy Options, First Steps, and Medicare, etc., are inappropriate entries for this field.

Field	Name	Action
10	Patient's Condition Related To	Check yes or no to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in Field 24. Indicate the name of the coverage source in field 10d (L&I, name of insurance company, etc.).
11	Insured's Policy Group or FECA (Federal Employees Compensation Act) Number	Primary insurance, when applicable. This information applies to the insured person listed in Field 4. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate the client has other insurance coverage and Medicaid is the payer of last resort.
11a	Insured's Date of Birth and Gender	Check the appropriate box when applicable for the insured's gender and enter the birthdate if different from field 3 in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
11c	Insurance Plan Name or Program Name	When applicable, show the insurance plan or program name to identify the primary insurance involved. (Note: This may or may not be associated with a group plan.)
11d	Is there another Health Benefit Plan?	Required if the client has other insurance. Indicate yes or no. If yes, you should have completed Fields 9a.-d. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check yes. If 11d is left blank, the claim may be processed and denied in error.
14	Date of Current Illness, Injury, or Pregnancy	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
15	If Patient Has Had Same or Similar Illness	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
16	Dates Patient Unable to Work in Current Occupation	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.
17	Name of Referring Physician or Other Source	When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. (Last Name, First Name)
17b	ID Number of Ordering/Referring Physician	When applicable, enter the NPI number of the ordering/referring physician. The provider reported here must be enrolled as a Washington State Medicaid provider. When billing for services provided to PCCM clients: Enter the National Provider Identifier (NPI of the PCCM who referred the client for the service(s).
18	Hospitalization Dates Related to Current Services	If applicable, enter the date in the following format: MMDDCCYY. Do not include hyphens, dashes, etc.

Field	Name	Action
19	Reserved for Local Use	This field is used for comments that require a Medical Assistance claims specialist to review a claim before payment is made. To make any of the following comments, put "SCI=" and the corresponding letter on the list below: ▪ **B** – BABY ON MOMS CLIENT ID o Use Twin A, Twin B; Triplet A, Triplet B, Triplet C when applicable. ▪ **F** – ENTERAL NUTRITION – CLIENT NOT ELIGIBLE FOR WIC ▪ **H** – CHILDREN WITH SPECIAL HEALTHCARE NEEDS ▪ **I** –INVOLUNTARY TREATMENT ACT (ITA) (Legal Status) ▪ **K** – NOT RELATED TO TERMINAL ILLNESS (Hospice Client) ▪ **V** – VOLUNTARY TREATMENT (Legal Status) ▪ **Y**– SPENDDOWN AMOUNT (and list the amount) This is also the location to put NDCs, if applicable. Indicate what line the NDC is for by putting "LN#" before the NDC **Note:** Baby on Mom's Client ID can only be used during the first 60 days of baby's life.
20	Outside Lab?	If applicable, check the appropriate box and enter charges.
21	Diagnosis or Nature of Illness or Injury	Enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.
22	Medicaid Resubmission	When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the TCN that verifies that the claim was originally submitted within the time limit. (The TCN number is the claim number listed on the Remittance and Status Report.) Also put TCN numbers in this field for adjusting or voiding claims. They must be in the following format: ▪ 7-300629600000340000-(replace/adjustment) ▪ 8-300629600000340000 (void/cancel)
23	Prior Authorization Number	When applicable. If the service or hardware being billed requires prior authorization, enter the assigned number.
24a	Date(s) of Service	Enter the "from" and "to" dates of service.
24b	Place of Service	Enter the appropriate two digit code. For example: 11- Office 31- Skilled Nursing Facility 32- Nursing Facility The Agency requires that a valid two-digit place of service be indicated that accurately reflects the place of service. Claims with inaccurate place of service designations will be denied.

Field	Name	Action
24d	Procedures, Services or Supplies CPT/HCPCS	Enter the appropriate procedure code for the service(s) being billed. When appropriate enter a modifier(s).
24e	Diagnosis Pointer	Enter the diagnosis pointer by entering a 1, 2, 3, or 4. The first diagnosis should be the principal diagnosis. Follow additional digit requirements per ICD-9-CM. Do not enter the actual diagnosis code in this field. Please do not enter a comma or any other punctuation in this field.
24f	Charges	Enter your usual and customary charge for the service performed. If billing for more than one unit, enter the total charge of the units being billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with the remittance amount.
24g	Days or Units	Enter the total number of days or units for each line. These figures must be whole units.
24i	ID Qualifier	Enter the taxonomy qualifier ZZ if applicable.
24j	Rendering Provider ID# If applicable~ Reference (Outside) Laboratory	Enter the taxonomy code in the top half of the field for the rendering provider if applicable. Enter the NPI for the rendering provider in the bottom half of the field. This information is only needed if it is different than fields 33a and 33b. For more information on taxonomy codes, please see Appendix L. The rendering provider must be enrolled as a Washington State Medicaid provider prior to start of treatment. Enter the NPI number of the reference (outside) laboratory here.
25	Federal Tax ID Number	Enter in the Federal Tax ID or Social Security number and indicate via the check boxes which number is being used.
26	Patient's Account Number	Not required (optional field for your internal purposes). Enter alpha and/or numeric characters only. For example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report (RA) under the heading Patient Account Number.
27	Accept Assignment?	Check the appropriate box.
28	Total Charge	Enter the sum of all charges indicated in Field 24F. Do not use dollar signs or decimals in this field.
29	Amount Paid	If there is an insurance payment, show the amount here, and attach a copy of the insurance EOB. If payment is received from a source(s) other than insurance, specify the source in Field 10d. Do not use dollar signs or decimals in this field or put prior Medicare, Medicare Advantage, or Medicaid payments here.
30	Balance Due	Enter total charges minus any amount(s) in Field 29. Do not use dollar signs or decimals in this field.
32	Service Facility Location Information	Enter the location address if different from Field 33 • Enter the location NPI • Enter the location Taxonomy. For more information on taxonomy codes, please see Appendix L. This field is required for Sleep Centers, Birthing Facilities, and Centers of Excellence when the location of service is different from the billing NPI's location.

Field	Name	Action
33	Physician's, Supplier's Billing Name, Address, Zip Code And Phone #	Enter the provider's Name and Address on all claim forms. • Enter the Billing Provider NPI • Enter the Billing Provider Taxonomy. For more information on taxonomy codes, please see Appendix L.

Appendix J: Completing Claim Form UB-04

The following instructions explain how to complete the UB-04 claim form and the "approved" form must be used when billing. The form will say "Approved OMB No. 0938-0997" on the bottom left hand corner. The instructions should be used to supplement the information in the National Uniform Billing Committee (NUBC) official UB-04 Data Specifications Manual. For fields that are situational and for code usage details not covered below please refer to the NUBC Manual.

Note: This guide applies only to paper UB-04 claims submitted to Medical Assistance. For information on HIPAA-compliant 837 transactions, please consult the appropriate companion documents for 837 transactions available on the Agency HIPAA website.

Note: All claims submitted to Washington State Medicaid to the ProviderOne system will require a taxonomy code for the Billing Provider. In form locator 81, Code B3 (qualifier) is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.

Form Locator	Name	Action
1	Billing Provider Name	Line 1: Provider Name Line 2: Street Address or Post Office Box Line 3: City, State, and Zip Code plus 4 Line 4:Telephone (& Fax)
2	Pay-to Name and Address	Report only if different than form Locator 1.
3a	Patient Control Number	Enter patient's unique (alpha and/or numeric) number assigned by the provider. This number will be printed on the Remittance and Status Report (RA) under the heading Patient Account Number.
3b	Medical/Health Record Number	Optional item. Enter alpha and/or numeric characters only. This entry is not returned on the RA.
4	Type of Bill	ProviderOne uses the Type of Bill for adjudication and pricing. The ProviderOne recommended TOBs are: Hospice 81X, 82X Home Health 32X, 33X, 34X Kidney Center 72X Inpatient Hospital 11X Outpatient Hospital 13X Nursing Home 21X Swing Bed 18X FQHC Crossover 77X, 73X RHC Crossover 71X

Form Locator	Name	Action
5	Federal Tax Number	Enter the federal tax identification number.
6	Statement Covers Period	Enter the from and through dates of service (MMDDYY). Overlapping fiscal/calendar years do not require split billing.
8a	Patient Name/Identifier	Enter the patient's ProviderOne Client ID. (123456789WA)
8b	Patient Name/Identifier	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility. If billing for a baby on mom's ID enter the baby's name here. If the baby is un-named use the mom's last name and "baby" as the first name.  **Note:** be sure to insert commas separating sections of the name!
9	Patient Address	Enter the address of the client who received the services.
10	Birthdate	Enter in the patient's date of birth in the following format: MMDDCCYY. (Example: 05102003 for May 10, 2003.) If billing baby on mom's ID enter the baby's birth date instead.
11	Sex	Indicate if the patient is male (M) or female (F). If billing baby on mom's ID enter the baby's sex here.
12	Admission Date	Indicate the start date of Admission.
13	Admission Hour	Enter the code for the hour of admission converted to 24 hour time as shown below: **CODE TIME AM CODE TIME PM** 00 12:00-12:59 (Midnight) 12 12:00-12:59 (Noon) 01 01:00-01:59 13 01:00-01:59 02 02:00-02:59 14 02:00-02:59 03 03:00-03:59 15 03:00-03:59 04 04:00-04:59 16 04:00-04:59 05 05:00-05:59 17 05:00-05:59 06 06:00-06:59 18 06:00-06:59 07 07:00-07:59 19 07:00-07:59 08 08:00-08:59 20 08:00-08:59 09 09:00-09:59 21 09:00-09:59 10 10:00-10:59 22 10:00-10;59 11 11:00-11:59 23 11:00-11:59 Refer to the NUBC manual for more information.
14	Priority(Type) of Visit	Required when patient is being admitted to the hospital for inpatient services. Refer to the NUBC manual for more information.
15	Admission Source	Indicate the source of referral for admission or visit. Refer to the NUBC manual for more information.
16	Discharge Hour	Enter the hour of discharge. Refer to the 24-hour time as shown in the coding table for Form Locator 13 and the NUBC manual for more information.
17	Status	Enter the code indicating patient status as of the discharge date. Refer to the NUBC manual for more information.

Form Locator	Name	Action
18-28	Condition Codes	*See NUBC Manual for Codes other than below:* Washington State assigned Condition Codes: Trauma: Qualified Trauma cases are identified by the following Codes TP Indicates a pediatric client (through age 14 only) with an Injury Severity Score (ISS) in the range of 9-12 TT Indicates a transferred client with an ISS that is less than 13 for adults or less than 9 for pediatric clients TV Indicates an ISS in the range of 13 to 15 TW Indicates an ISS in the range of 16 to 24 TX Indicates an ISS in the range of 25 to 34 TY Indicates an ISS in the range of 35 to 44 TZ Indicates an ISS of 45 or greater
29	Accident State	If applicable, enter the state in which the accident occurred. (Example: OR, CA, etc)
31-34	Occurrence Code and Dates	Refer to the NUBC manual for more information. Not required on a Hospice, Kidney center, Home Health or SNF claims.
35-36	Occurrence Span Codes and Dates	Refer to the NUBC manual for more information.
38	Responsible Party name and address	Enter the information for the claim addressee.
39-41	Value codes and Amounts	See NUBC Manual for Codes other than below: **Value Code 66** for EMER patient liability on Inpatient Hospital claims, then enter the Patient Participation Amount. . **Value Code 66** for Spenddown on Institutional Hospital claims, then enter the Patient Participation Amount **Value Code 24**-Enter this code in the code field with the Patient Class immediately following in the amount field. See page C.1 in the Nursing Facilities billing instructions for valid Patient Class codes. (e.g., 20.00=class code 20). **Value Code 31**-Enter this code in the code field with the Patient Participation amount for the entire month immediately following in the amount field. (Nursing Home claims only.) **Value Code 54 -** Enter this code in the code field with the newborn birth weight in grams in the amount field (no decimals). Right justify the weight in grams to the left of the dollars/cents delimiter. (If billing software requires the decimal in Value Code field, enter the weight in grams then decimal point 00. Example 2499.00)

Form Locator	Name	Action
42	Revenue Code	Revenue Codes must be valid for the Type of Bill or facility. For example, revenue code usage for Hospice may differ from a hospital. a. For Hospice, Home Health, Kidney Center and Nursing Home billing see the individual Billing Instructions. b. For Inpatient and Outpatient Hospital services see Medical Assistance Revenue Code Grid. c. On the final page of your claim, form locator 42, line 23 will require rev code 0001 with your claim total in form locator 47 line 23.
43	Description	Enter a written description of the related revenue categories included on the bill. The Agency is collecting NDC information on Centers for Medicare and Medicaid Services designated, physician administered drugs in the outpatient hospital setting and for Kidney Centers (revenue Codes 0634-0637 drugs with procedures). See Memo 08-23 for the NDC reporting format. When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug for the specified detail line. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units. Refer to the NUBC manual for more information.
44	HCPCS/RATE/HIPPS Codes	When applicable, enter the HCPCS/CPT/RATE codes. Outpatient HCPCS – see Revenue Code Grid for Revenue code/HCPCS combination requirements. Inpatient Rates – required when a room and board revenue code is reported Modifiers are entered in this field when applicable attached to the qualifying code line.
45	Service Date	Required on outpatient hospital, Kidney Center, Hospice, Nursing Home, and Home Health claims. On each line, enter the date of service.
46	Service Units	Enter the units of service for each revenue code. Please do not use decimal points. (e.g. 1 unit = 1)
47	Total Charges	Enter the total charge for each revenue code or procedure code entry. Line 23: This entry must be the sum of the individual charges.
48	Non-Covered Charges	Enter the amount required by contract with the Agency. Enter charges for non-covered services performed during the stay or charges paid by another payer (Medicare) when all services must be reported on the inpatient claims.
50 a-c	Payer Name	Enter Washington Medicaid for the Medicaid payer identification. Enter the name of the third party payer if applicable: 50a–Primary Payer. 50b–Secondary Payer. 50c–Tertiary Payer

Form Locator	Name	Action
51	Health Plan ID	For Washington Medicaid leave blank. Enter the health plan identification number (if known) in 51 a, b, c depending on whether the insurance is primary, secondary, or tertiary.
52 a-c	Release of Information Certification Indicator Required	Indicate whether the patient or patient's legal representative has signed a statement permitting the provider to release data to other organizations**.** The Release of Information is limited to the information carried on the claim. I = Informed Consent to Release Medical Information. (Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.) Y = Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. Refer to the NUBC manual for more information.
53 a-c	Assignment of Benefits Certification Indicator Required	No data available.
54 a-c	Prior Payments	Enter the amount that has been received (if any) toward payment of the claim from an insurance carrier prior to billing the Agency.
55	Estimate Amount Due	The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments)
56	NPI	Enter the NPI for the billing provider. For more information on taxonomy codes, please see Appendix L.
57 a-c	Other Billing Provider ID	A unique identification number assigned to the provider submitting the bill by the health plan. Not Required. Agency does not assign nor require unique identification number other than NPI.
58 a-c	Insured's Name	Enter the insured's last name, first name, and middle initial exactly as it appears on the client services card or other proof of eligibility. **Note:** be sure to insert commas separating sections of the name! If the recipient is covered by insurance other than Medicaid, enter the name of the individual in whose name the insurance is carried. Carry through the payer line scheme reported in Form Locator 50 A-C. Refer to the NUBC manual for more information
59 a-c	Patient's Relationship to Insured	Enter 18 when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this field.

Form Locator	Name	Action
60 a-c	Insured's Unique ID	Enter all of the insured's unique identification numbers assigned by any payer organizations. Carry through the payer line scheme reported in Form Locator 50 A-C. Enter the ProviderOne Client ID exactly as it appears on the Medicaid ID card or other proof of eligibility. Example: 123456789WA). Refer to the NUBC manual for more information
61 a-c	Group Name	Refer to the NUBC manual
62 a-c	Insurance Group Number	Refer to the NUBC manual
63 a-c	Treatment Authorization Codes	Enter the Prior Authorization (PA) number issued by the Agency or Expedited Authorization Number (EPA) located in the appropriate program billing instructions for the billed service if required. Carry through the payer line scheme reported in Form Locator 50 A-C If the claim meets the qualifications for Medical Inpatient Detox (MID) use the following EPA numbers. Please see the Inpatient Hospital Billing Instructions for additional information. • Acute alcohol detoxification use 870000433 • Acute drug detoxification use 870000435
64 a-c	Document Control Number	When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the TCN that verifies that the claim was originally submitted within the time limit. (The TCN number is the claim number listed on the Remittance Advice.) Also put TCN numbers in this field for adjusting or voiding claims. They must be in the following format: ▪ 7-300629600000340000-(replace/adjustment) ▪ 8-300629600000340000 (void/cancel)
65 a-c	Employer Name	If applicable, enter the employer name of the insured. Carry through the payer line scheme reported in Form Locator 50 a-c.
66	Diagnosis and Procedure Code Qualifier	Required. Enter the qualifier that identifies the version of the International Classification of Diseases (ICD) reported: 9 – Ninth Revision 0 – Tenth Revision
67	Principal Diagnosis Code	Principal Diagnosis Code (the condition established after study to be chiefly responsible for causing the use of facility services) Required: • Present on Admission (POA) Indicator - See NUBC Manual for usage guidelines • Review the Inpatient billing instructions for additional information http://hrsa.dshs.wa.gov/Download/Billing_Instructions_Webpages/Hospital_Inpatient.html

Form Locator	Name	Action
67a-q	Other Diagnosis Codes	Enter the most specific ICD diagnosis codes that correspond to additional conditions that co-exist at the time of service or affect the length of stay. • For newborns, include the appropriate birth weight code (765.11 to 765.199) • POA Indicator for applicable secondary diagnosis • Refer to the NUBC manual for more information
69	Admitting Diagnosis Code	Enter the presenting symptom (diagnosis) and the reason for the patient's visit. Refer to the NUBC manual for more information
70a-c	Patient's Reason for Visit	Refer to the NUBC manual for more information
72a-c	External Cause of Injury	Refer to the NUBC manual for more information
74	Other Procedure Codes and Date	**Inpatient**: Enter the code identifying the principal ICD surgical or obstetrical procedure and the date on which either was performed. Enter the date in MMDDYY format Refer to the NUBC manual for more information
74a-e	Other Procedure Codes and Date	**Inpatient**: Enter the codes identifying all other significant procedures performed during the billing period covered by the claim and the dates on which the procedures were performed. Refer to the NUBC manual for more information
76	Attending Provider Name and Identifiers	Enter the NPI number for the attending physician (the physician primarily responsible for the care of the patient) or the resident physician. The NPI number of the Advanced Registered Nurse Practitioners (ARNPs) may also be reported in this form locator if they were primarily responsible for services in the hospital setting. Report in this Form Locator the NPI number of the physician ordering lab tests or X-ray services. **Note:** All providers reported here must be enrolled as a Washington State Medicaid Provider.
77	Operating Physician Name and Identifiers	Required. Enter the NPI number for the operating physician when a surgical procedure code is listed on the claim. **Note:** All providers reported here must be enrolled as a Washington State Medicaid Provider.
78-79	Other Provider (Individual) Name and Identifiers	Enter the NPI number of other treating providers or the referring provider. Enter the NPI number for a Primary Care Case Management, or Skilled Nursing Facility. **Note:** All providers reported here must be enrolled as a Washington State Medicaid Provider.

Form Locator	Name	Action
80	Remarks	Enter any comments that would help in processing a claim for payment. Possible comments include: ▪ SCI =B – Baby on Moms ID ▪ SCI =I – Involuntary Treatment Act (ITA) ▪ SCI =V – Voluntary Treatment ▪ Twin A, Twin B; Triplet A, Triplet B, Triplet C when using baby on moms ID Refer to the NUBC manual for more information.
81 a-d	Code-Code	The Billing provider's NPI entered in Form Locator 56 is mapped to a taxonomy code (s) that is needed to identify the provider in the ProviderOne claims processing system. The provider must enter qualifier code B3 and the reported taxonomy code in this Form Locator that corresponds to the service billed on this claim. For any other code qualifiers, please refer to the NUBC manual.

Appendix K: Completing Claim Form 2006 ADA Claim Form

Field	Name	Action
2	Predetermination/Preauthorization Number	Place the required prior authorization number or EPA number in this field.
3	Company/Plan Name, Address, City, State, Zip Code	Enter the claims address for the Health Care Authority.
4	Other Dental or Medical Coverage	Check the appropriate box.
5	Name of Policyholder/Subscriber (Last, First, Middle Initial, Suffix)	If different from the patient, enter the name of the subscriber.
6	Date of Birth	Enter the subscriber's date of birth. Hyphens, dashes, etc. are not needed.
8	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the subscriber's SSN or other identifier assigned by the payer.
9	Plan/Group Number	If the client has third party coverage, enter the dental plan number of the subscriber.
10	Relationship to Primary Policyholder/Subscriber	Check the applicable box.
11	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter any other applicable third party insurance.
12	12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility.  **Note:** be sure to insert commas separating sections of the name!
13	Date of Birth (MMDDCCYY)	Enter the client's date of birth. Hyphens, dashes, etc. are not needed.
14	Gender	Check the applicable box.
15	Policyholder/Subscriber Identifier (SSN or ID#)	Enter the patient's ProviderOne Client ID (123456789WA)
16	Plan/Group Number	Enter the subscriber's group Plan or Policy Number.
18	Relationship to Policyholder/Subscriber	Check the appropriate box.
20	Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code	Enter the last name, first name, and middle initial of the client receiving services exactly as it appears on the client services card or other proof of eligibility.  **Note:** This field is not required if "self" is checked in box 18.
21	Date of Birth (MMDDCCYY)	Enter the client's date of birth. Hyphens, dashes, etc. are not needed.  **Note:** This field is not required if "self" is checked in box 18.
22	Gender	Check the appropriate box.  **Note:** This field is not required if "self" is checked in box 18.

Field	Name	Action
23	Patient ID/Account #	Not required (optional field for your internal purposes). Enter an alpha or numeric character only. For example, a medical record number or patient account number. This number will be printed on the Remittance and Status Report (RA) under the heading Patient Account Number.
24	Procedure Date (MMDDCCYY)	Enter the eight-digit date of service, indicating month, day, and year (e.g., April 1, 2007 = 04012007). Hyphens, dashes, etc. are not needed.
25	Area of Oral Cavity	If the procedure code requires an arch or a quadrant designation, enter one of the following: 01 Maxillary area 02 Mandibular area 10 Upper right quadrant 20 Upper left quadrant 30 Lower left quadrant 40 Lower right quadrant
27	Tooth Number(s) or Letter(s)	Enter the appropriate tooth number, letter(s): 1. 1 through 32 for permanent teeth 2. A through T for primary teeth 3. 51 through 82 or AS through TS for supernumerary teeth **4. Only one tooth number may be billed per line** Do not fill in preceding zeros for tooth numbers (e.g. tooth 1)
28	Tooth Surface	Enter the appropriate letter from the list below to indicate the tooth surface. Up to five surfaces may be listed in this column (Please separate with a comma): B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal Note: Make entries in this field only if the procedure requires a tooth surface.
29	Procedure Code	Enter the appropriate current CDT procedure code that represents the procedure or service performed. The use of any other procedure code(s) will result in denial of payment. **Note**: The Agency only covers procedure codes listed on our fee schedule that have a dollar amount indicated.
30	Description	Give a brief written description of the services rendered. When billing for general anesthesia or IV sedation, enter the actual beginning and ending time.
31	Fee	Enter your usual and customary fee (not the Agency's maximum allowable rate) for each service rendered. If fee schedule indicates to bill Acquisition Cost (AC) please bill your acquisition cost.
32	Other Fee(s)	

Field	Name	Action
33	Total Fee	Enter the total charges. Do not include decimal points or dollar signs.
34	Missing Teeth Information	Place an "X" on the appropriate missing teeth.
35	Remarks	Enter appropriate comments in this field ▪ To indicate a payment by another plan, enter "insurance payment" and the amount. Attach the insurance EOB to the claim. ▪ If processing a void, enter the TCN in this field preceded by an 8. (e.g. 8-123456789012345678) ▪ If processing an adjustment or replacement enter the TCN in this field preceded by a 7. (e.g. 7-123456789012345678) ▪ If the claim is a adjustment and indicating an insurance payment use the following format – 7-123456789012345678 - $123.45 ▪ Indicate the client's Spenddown amount, enter **SCI=Y** and then the amount.

Field	Name	Action
38	Place of Treatment	The Agency defines the following places of service for paper claims when a place of treatment box is checked but no two-digit place of service is indicated: **Box checked** — **Place of Service (POS)** Office — Dental office (POS 11) Hospital — Outpatient hospital (POS 22) ECF — Skilled nursing facility (POS 31) Other — The Agency will not allow place of service "other" without a two digit place of service indicated. If the services rendered are not in one of the places of service as indicated above, then the two-digit POS **must** be indicated in field 38. The Agency considers the following places of service for dental claims (not all services are covered in all places of service) **Office** **11** dental office **Hosp** **21** inpatient hospital **22** outpatient hospital **23** hospital emergency room **ECF** **31** skilled nursing facility **32** nursing facility **54** intermediate care facility/mentally retarded **Other** **03** school-based services **12** client's residence **24** professional services in an ambulatory surgery center **50** federally qualified health center **71** state or public health clinic (department) The Agency requires that a valid two-digit place of service be indicated that accurately reflects the place of service. Claims with inaccurate place of service designations will be denied.
39	Number of Enclosures	Check the appropriate box. Note: Do not send X-rays when billing for services.
40	Is Treatment for Orthodontics?	Check the appropriate box.
41	Date Appliance Placed (MMDDCCYY)	This field **must be completed** for orthodontic treatment.
42	Months of Treatment Remaining	If applicable, enter the months of treatment remaining.
43	Replacement of Prosthesis?	Check appropriate box. If "yes," enter the reason for replacement in field 35 (Remarks).
44	Date Prior Placement (MMDDCCYY)	Enter the appropriate date if "yes" is check for field 43.

Field	Name	Action
45	Treatment Resulting from	Check the appropriate box.
46	Date of Accident (MMDDCCYY)	If applicable, enter the date of accident.
47	Auto Accident State	Enter the two letter abbreviation for whatever state the accident was in, if applicable.
48	Name, Address, City, State, Zip Code	Enter the practice or business name and address as recorded with the Agency. If a solo practice, enter the dentist name and business address as recorded with the Agency.
49	NPI	Enter your National Provider Identifier (NPI). It is this code by which providers are identified, not by provider name. Without this number the claim will be denied. The provider must be enrolled as a Medicaid provider prior to start of treatment.
50	License Number	Enter the billing dentist's license number.
51	SSN or TIN	Enter the billing dentist's SSN or TIN.
52a	Additional Provider ID	Enter the taxonomy for the billing provider. For more information on taxonomy codes, please see Appendix L.
53	Treating Dentist and Treatment Location Information	Enter the treating dentist's signature and date.
54	NPI	Enter the treating provider NPI if it is different from the billing provider NPI. The treating provider must be enrolled as a Medicaid provider prior to start of treatment.
55	License Number	Enter the treating dentist's license number.
56	Address, City, State, Zip Code	Enter the treating dentists address, city state and zip code.
56a	Provider Specialty Code	Enter in the treating provider taxonomy if an NPI was entered in box 54.
58	Additional Provider ID	This field is not used by the Agency.

Appendix L: Taxonomy and ProviderOne

A taxonomy code indicates a provider's type, specialty, and subspecialty. Providers will need to use taxonomy for billing and servicing (if applicable) providers on the claim in ProviderOne.
The general term "taxonomy" refers to a classification system. For medical billing and payment, "provider taxonomy" refers to the national provider classification system defined by the Centers for Medicare and Medicaid Services (CMS). This national classification system was defined as part of the National Provider Identification (NPI) rule of the Health Insurance Portability and Accountability (HIPAA) Act.

There are three steps using taxonomy in ProviderOne:

1. **Verify the taxonomy to be billed with is loaded in the provider's ProviderOne provider file.**
   - This information can be found under the "**Manage Provider Information**" hyperlink from the ProviderOne homepage. On the Business Process Wizard page, taxonomy is referred to as "Specializations". There are two profiles in ProviderOne that allow the user to edit or add to the provider file- **EXT Provider File Maintenance** and **EXT Provider Super User** and other profiles only allow viewing the file.
   - Only a subset of the national taxonomies are being used by the Agency. Only those taxonomies shown in the drop down list in the provider file are being used. There are literally thousands of national taxonomies that the Agency will not be using.
   - Providers are NOT required to bill the Agency with the taxonomy reported to CMS. Please bill with a taxonomy the Agency is using.
2. **Use the verified taxonomy for billing and rendering/servicing (if applicable) providers on the claim.** Taxonomy is not required for referring providers. (see Memo 10-22.)
3. **Make sure the service billed is allowed by the taxonomy.**
   - The service on the billed claim must be associated with the taxonomy and be within the scope of licensure for the provider supplying or performing the service. For example, oxygen services require an oxygen taxonomy, durable medical equipment (DME) billings require a DME taxonomy, dental services require a dental taxonomy, etc.

Note: Medical Assistance requires taxonomy on Medicare crossovers. Providers must include taxonomy on Medicare claims when the client is also eligible for Medicaid as a secondary payer. Medicare will pass the taxonomy on these claims to Medical Assistance and if the taxonomy is missing on Medicare claims passed to Medical Assistance, these claims will deny.

Medical Assistance does not receive TPL claims directly from other payers (other than Medicare). When billing Medical Assistance directly for TPL coverage, follow Medical Assistance rules about taxonomy (i.e., make sure the taxonomy is associated with the provider and that the taxonomy description aligns with the service).

Appendix M: Medicare Crossover Claim Payment Methodology

Crossover Payment Methodology
Professional Services (CMS-1500, 837P)
Refer to WAC 388-517-0320

- Medical Assistance compares the Medical Assistance allowed amount to Medicare's allowed amount for the service, selects the lesser amount of the two, then deducts Medicare's payment from the amount selected.
- If there is a balance due, Medical Assistance pays the client's cost sharing liability (deductible, coinsurance, or co-pay) up to the lesser of the allowed amounts.
- If there is no balance due, Medical Assistance does not make any crossover claim payment because Medicare's payment exceeds the lesser of the allowed amounts.

The Agency cannot make direct payments to clients to cover the client's cost sharing liability (deductible, coinsurance, or co-pay) amount of Part B Medicare claim. The Agency **can** pay these costs to the provider on behalf of the client when:

- The provider **accepts** assignment; and
- The total combined payment to the provider from Medicare and Medical Assistance does not exceed Medicare or Medical Assistance's allowed amount for the service, whichever is less.

Note: The Agency is revising **codes** that may be noncovered by Medical Assistance, but the services are covered. If the service is covered by Medical Assistance, but the code is not, then the Agency may pay as follows:

Medicare Allowed – Medicare Paid = The Agency payment

Institutional Services (UB-04, 837I)

Crossover Payment Methodology

Institutional Services (UB-04, 837I)

- Outpatient Hospital
  - Payment equals the lesser of Medical Assistance allowed amount minus the Medicare paid amount up to the client's cost sharing liability (deductible, coinsurance, or co-pay).

- RHC-Rural Health Clinic
  - For RHCs who bill for Medicare Encounteer Services payment equals the Rural Health Clinic (RHC) Per Diem rate on file with the Agency minus the Medicare paid amount. These RHC claims are submitted using Type of Bill 71x and Billing provider Taxonomy 261QR1300X.

- FQHC-Federally Qualified Health Clinic
  - For FQHCs who bill for FQHC Encounteer Services, payment equals the Medicare coinsurance amount. These FQHCs bill crossover claims using Type of Bill 73x and Billing Provider Taxonomy 261QF0400X.

- Inpatient Hospital for client with both Medicare Part A and Part B coverage
  - Payment equals **the lesser of** Medical Assistance allowed amount minus the Medicare paid amount, up to the client's cost sharing liability (deductible, coinsurance, or co-pay).

Note: The Agency would adjust any payment amounts if the client has a Commercial Medicare supplement policy (TPL) and that supplement payer makes a payment after Medicare. In that case the formula would be:

Medical Assistance allowed – Medicare Paid – TPL Paid = The Agency payment